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THE EXPERIENCES OF TRANSGENDER FEMALE SEX WORKERS WITHIN THEIR FAMILIES, OCCUPATION, AND THE HEALTHCARE SYSTEM.

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A mini-thesis submitted in partial fulfilment for the degree of Master of Arts in Psychology in the Department of Psychology University of the Western Cape Bellville 2018.

Keywords: *Transgender; sex work; HIV; violence; discrimination; stigma; poverty; heteronormativity; gender; intersectional feminism*

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Abstract

There is a dearth of scholarly literature surrounding transgender female sex workers (TFSW) within South Africa. Their voices are often marginalised and not adequately heard in the literature and in a society that generally views gender as a fundamental element of the self, determining their subject positions against binaried heteronormative gender ideals. This process of the 'othering' of TFSW, is exacerbated by the moralistic judging of their occupation of sex work. This has left many TFSWs vulnerable to emotional abuse such as being socially stigmatised, discriminated against and socially isolated. The literature further echoes vulnerability to physical violence, such as hate crimes, rape, heightened HIV infection, homelessness, police brutality and murder. The current study aimed to explore the subjective experiences of TFSW within their families, occupations and the healthcare system within the Cape Town metropole, South Africa. The study was framed within an intersectional feminist epistemological position, highlighting intersecting identities that marginalise groups of people. Informant driven sampling was used in the case of this study where a total of eleven participants were individually interviewed using a semi-structured approach – interviews ranged from 35-90 minutes. The data collected was subsequently analysed using thematic analysis and the three themes that emerged were: transgender female (TGF), Sex work and HIV. Family rejection and abuse based on participants non-conforming gender identity was expressed by participants. Repressive home circumstances led to many opting to live on the street. Participants described being introduced to sex work through a network of other homeless TFSW, also described as 'Sisters' (who fulfil the role of family) as a means of survival. Sex work for TGFs is a particularly dangerous job, as sex workers run the risk of being exposed as TGFs, often resulting in severe physical harm for some. To cope with their severe realities of violence and homelessness, many reported turning to substances, such as alcohol and methamphetamine. A total of ten participants described being HIV positive and adherence was very poor among the group. This could be attributed to stigmatisation from health workers, substance use and homelessness. This group of women, though vulnerable and structurally oppressed, displayed exceptional resilience. It is suggested that further research should be conducted on this group in the South African context for a clearer understanding of their needs and improved policy, as well as interventions for TFSW.

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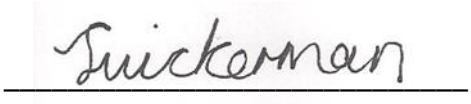
Declaration

I hereby declare that the following research, 'The experiences of transgender female sex workers within their families, occupation and the health care system', is my own work and all the sources used or quoted have been properly and fully acknowledged by means of complete references in accordance with the American Psychological Association referencing convention.

Shelley Ann Vickerman **November 2018**



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Acknowledgements

First and foremost, I would like to thank the 11 incredible women who shared their stories with me. My wish for you is that a day will come, when you will no longer be required to use your incredible resilience in order to survive.

To my supervisors, Umesh, thank you for constantly overestimating my ability and having my back, I hope that one day I will see myself as you see me. Writing this thesis was so incredibly hard, but in the words of Bob Dylan "Behind every beautiful thing, there's some kind of pain", thank you for witnessing my pain and helping me realise that we have made something beautiful.

Prof van Wyk, you have taught me more academically in a single year than any educator has. I feel privileged to have been supervised by you, as it is clear that this is your calling. Thank you for pushing me when I was so resistant to moving forward – I am a stronger academic because of you.

To my parents, Patricia and John Vickerman, you have sacrificed so much for me. Everything I am, all I have achieved, and everything I will ever be is thanks to you. This degree will be as much yours as it will be mine. Mom, thank you for showing me what it means to love with no bounds. Dad, whenever I felt like giving up, I thought of you, who at 74 years old still wakes up at 6:30 am every morning for a full day of work. I love you both.

My dearest mon amour, Anton. This will be the second thesis completed between the two of us in less than a year, which is why I am so certain that we are made for one another – how else we would have made it through this? You have carried me through this process, literally, at times. Thank you for holding me as I sobbed February away - to me you are perfect. I love you on ridiculous levels.

Marelize, there are really no words. Thank you for being the reason I wasn't absent 90% of my high school career. Tamzyn, you have shown the most incredible patience throughout this gruelling journey. Lesley, you were always with me (on the other side of a screen), no matter how far. Corne, thank you for always being able to strike a laugh in me during difficult times. Magda and Natasha, I am so grateful to have been placed with two of you during my internship.

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Steven and Siphelelisiwe, thanks for all the encouraging phone calls. Kulthum, thanks for being my non-biological twin! Kyle, I would not have been in this programme, had you not pushed me to apply, thank you! To my favourite cousin, Kim, thank you for reminding me that I don't need to take life so seriously.

My former lecturer and employer, Lynn Hendricks, and honours supervisor, Nina du Plessis, the two of you struck the match that ignited my love for research. To the nine incredible women who were in the MA Psychology 'Apple class' with me: Donnay, Emma, Farhana, Fatiema, Mulalo, Nazeema, Shantay, Tessa and Zaida, I value each of you!

To my family at the psychology department at UWC, you have constantly inspired me to be more than what I am, while always making me feel that I am enough. Prof Mwaba, not only do I hold you in the highest esteem as an academic, but also as a person. Uncle Shaz, thank you for always keeping your office doors wide open for me to come sit and cry (some would call that insanity). Saabs, thank you for being a wonderful example to a class of 10 young women by showing us what we can be. Prof Michelle Andipatin, thank you for being my spiritual advisor through difficult times. Dr Maria Florence, thank you for embracing my alternative approach to stats, you are lovely. Mariska, thanks you for entertaining my ridiculous ideas for reality shows. Athena, Charl and Serena, thank you for taking me back to where my love for psychology started – the community. Finally, to Janine and Ms Klink, my psych department mommies, you are both the cement of that department and very loved.

A special mention to my uncle Kevin, aunty Petro (X2); also, to my new family members, aunty Ansley, uncle Derrick, Antoinette, Monica, Renier, Khara and Johan. Each one of you are special to me!

To ANOVA Health Institute, thank you for the amazing work you do; for allowing me to conduct my interviews at your clinic; and to all the staff for making me feel welcome. To Gayle and Dr Johan, thank you for the emotional support you provided throughout the interviewing process.

To my late siblings, Owen, Wendy and Dean Vickerman – I know you are proud, but I wish you were here.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychological Association
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
DSM	Diagnostic Statistical Manual
GBV	Gender based violence
HIV	Human Immunodeficiency Virus
LGBTIQ+	Lesbian, gay, bisexual, transgender/transsexual, intersex and queer/questioning
MtF	Male-to-female
NGO	Non-governmental organisation
PLWHIV	People living with HIV
SW	Sex work
TGF	Transgender female
TFSW	Transgender female sex workers
TGFY	Transgender female youth
WHO	World Health Organization

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Chapter One

Introduction

1.1 Background

An individual's identity comprises two principal aspects, i.e. gender, and the work in which they engage. Being transgender female (TGF) and a sex worker (SW) are two identities that fit the term "double jeopardy" (Purdie-Vaughns & Eibach, 2008). Transgender female sex workers (TFSW) face compounded discrimination, based on their 'non-conforming' gender identity and highly stigmatised work (Nemoto, Bödeker & Iwamoto, 2011; Poteat et al., 2016). They are exceptionally vulnerable to a number of social problems, such as HIV, mental health disorders, substance abuse, and sexual, emotional and physical abuse, and police brutality (Goldblum et al., 2012; Nemoto et al., 2011; Nemoto, Bödeker, Iwamoto, & Sakata, 2014a; Sausa, Keatley, & Operario, 2007). Regardless of the substantial evidence indicating how vulnerable TFSW are, a dearth of literature exists relating to this marginalised population - particularly in the African context.

The current study focused on uncovering and exploring the experiences of TFSW, thereby, making it necessary to define certain prerequisite terminologies, i.e. sex, gender, transgender and sexual orientation, in order to establish context. The understanding of the aforementioned concepts is subject to much contestation (Woodward, 2016), as they are both context- and discipline-specific. Moreover, the identity of 'sex worker' is highly stigmatised from a moral perspective, with most religious texts condemning sex work (Euchner & Knill, 2015), in addition to sex work being largely criminalised when viewing the law from a global perspective (Lazarus et al., 2012; Scambler & Paoli, 2008).

For this study, assigned birth sex will refer to the sex that an individual is given at birth, i.e. 'male' or 'female' based on their biological genitalia (Woodward, 2016). Gender, however, has been described as a social construct, which is determined by factors like culture, and commonly understood as 'masculine' – relating to male and 'feminine' – relating to female. According to Patricia Collins (1990; 2000), gender can never be understood outside of power, as these social identities are a product of historical domination – through successfully reinforcing oppression among women, along with other social identities, e.g. race and class. Individuals are restricted to a binaried system where gender is usually split into two categories of male and female (Cashore & Tuason, 2009), as opposed to on a continuum. Individuals who

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find themselves between the binaries or deviating from their assigned birth sex, thus placing the individual in a socially devalued position (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; Goldberg, 2013). This form of marginalisation is not surprising, considering that society is constructed on and saturated in hegemonic ideologies – dominant belief systems that maintain societal and hierarchical oppression (Stoddart, 2007).

Categories of gender are mostly understood through a hegemonic perspective, where the dominant exists in relation to its subordinate (Beasley, 2005). The dominant and subordinate positionalities relating to issues like race, class, and gender are imposed onto the masses by those in power, fostering structurally violent hierarchies and disempowering any group with a 'deviant identity' based on race, class, gender or sexuality (Hare-Mustin, 2014; Swan, 2018). Conway (2008) unpacks how the Apartheid regime and colonisation promoted white hegemonic masculinity through constructing and maintaining 'deviant identities'. These deviant identities are often judged as immoral and are a product of negative social sanctions placed on groups of people who are 'outliers' from the 'normative order'(Piddocke, 1968). Deviant identities can be used as a tool of oppression through enforcing an outsider consciousness , which is only furthered by socially stigmatised discourse aimed at specific groups (Bulhan, 1985). Crediting stigmatisation among groups at an institutional level can cause these negative attitudes and beliefs to filter through various the structures of society (Campbell, 2006), into the psyche of those who are stigmatised.

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Oppressive discourse is represented in local discourse, where the term '*Moffie*' is used to describe an effeminate or homosexual male (often used in a derogatory manner); consequently, creating a category that represents a subordinate or 'lesser than' masculinity in relation to dominant masculinity (Ratele, Shefer, Strebel, & Fouten, 2014). Swan (2018) further describes gender as being constantly reconstructed within its context using the word '*stabane*' (an isiZulu word) as an example. *Stabane* is a word that was originally used to describe an intersexed individual, which has transformed into a derogatory term aimed at homosexuals.

Deviating from the hegemonic binaries of gender can result in detrimental social consequences for the individual in question by negatively impacting their social positioning in society. These negative impacts are often resultant of issues like gender-based discrimination (Testa et al., 2012). Furthermore, outcomes of social discrimination based on having a 'non-conforming' gender identity can negatively impact one's physical and mental health (van der Merwe, 2018). 'Conventional' gender identity is that of cis-gender, where an individual's

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gender identity corresponds with that of their assigned birth sex, with the juxtaposition of cis-gender being 'transgender'. Transgender is an umbrella term that is used to describe individuals who vary from that of their assigned birth gender, which can often be seen in a gender performance contrary to the norms usually associated with their natal gender (Bockting, 2015; Serano, 2007).

The research on TGFs focuses on a group of individuals who are understood to have been assigned a male identity at birth – but identify as female. Identifying as female itself brings forth an array of challenges for TGFs. The Oxford University Press (2018) define female as, "*Of or denoting the sex that can bear offspring or produce eggs, distinguished biologically by the production of gametes (ova) which can be fertilized by male gametes*." Transgender female's gender identity is immediately discredited based on this definition of female that rests on biology. Thus contributing to the exclusion of TGFs (van der Merwe, 2018) only to fuel the restrictive narrative of what it means to be a 'real woman'.

The concept of transgender has been, and continues to be misunderstood, discredited and ignored (Budhwani et al., 2017; Miller & Grollman, 2015). There is a dearth of literature available surrounding this population. In an article that focused on inequalities faced by sexual minorities (lesbian, gay and bisexual), the transgender population was included with those that fall under sexual minorities Math & Shesadri, 2013). Their inclusion diminishes transgender individuals' identity by incorrectly basing their identity on sex, as opposed to gender. The Math and Shesadri (2013) is an example of how gender, sex and sexual orientation are used interchangeably, thus only perpetuating the confusion that is attached to the concept of transgender. There is a lack of literature surrounding the transgender population – not only in South Africa, but also the African continent, (Jobson, Theron, Kaggwa, & Kim, 2012) with these authors refer to the population as "invisible or ignored".

Post-modernist researchers argue that gender is fluid as opposed to a categorical identity (Butler, 1990). Butler (1990) further states that the existence of gender is oppressive, as it is directly aligned to control, by constraining individuals within the boundaries of binaries. Transgender females are positioned outside the normative expectations of society, also known as the 'heteronormative', where norms are based on the dominant i.e. heterosexual, as normal (Schilt, Westbrook, & Schilt, 2009). The preceding information is but one of many reasons why TGFs find themselves part of a minority group, consequently, furthering their social exclusion and stigma-related oppression (Singh, 2015).

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Before the release of the Diagnostic Statistical Manual of Mental Disorders (DSM-5) in 2013, the American Psychiatric Association (APA) diagnosed individuals who identify as transgender with Gender Identity Disorder (American Psychiatric Association, 2000, 2013a). This diagnostic criterion was based on the individual's gender identity being incongruent to their birth sex. However, it was altered in the DSM-5 (2013) to Gender Dysphoria, because of "the connotation that the patient is 'disordered'" (American Psychiatric Association, 2013b)The presence of this diagnosis in the DSM-5 should be noted as having contributed to some dire implications for this population (Lev, 2013). Among some of these implications is the perpetuation of the stigma associated with being pathologized, based on the fact that the person has chosen to live by their 'true' gender (Lev, 2013). Therefore, it can be argued that the diagnosis and pathologizing of a gender identity only further oppresses individuals who identify as transgender, rather than protecting them. While psychology locates Gender Dysphoria within the individual, feminist, theories argue the feelings of distress that the individual's experience is a direct result of societal constructions, relating to oppressive power structures and constraining gender binaries (Butler, 1990).

The APA supports the presence of Gender Dysphoria, as it believes that without a diagnosis, this population will not receive proper health and legal services (American Psychiatric Association, 2013). However, current literature refutes this logic, with many transgendered persons being refused medical treatment purely based on their (trans-) gender identity (Miller & Grollman, 2015; Stroumsa, 2014). Abuse, discrimination, and maltreatment from health workers often result in transgender individuals avoiding health facilities, resulting in poor health (Stevens, 2012; Stroumsa, 2014; Winter et al, 2016). Healthcare staff has been reported to breach confidentiality and deny TGFs access to medical services, resulting in negative implications to their health (Scorgie et al., 2013). The levels of discrimination and victimisation experienced by the transgender population are disproportionate to those of the cis-gender population, which relate to the high rates of attempted and successful suicides among them (Clements-Nolle & Marx, 2006; Goldblum et al., 2012). Clements-Nolle and Marx (2006) conducted a study in San Francisco on the topic of suicide among the transgender population, where 32% of the respondents reported attempting suicide at some point throughout their lives. These attempted suicide rates are indicative of the pervasive mental health problems that the TGF community face, such as depression; generalised anxiety disorder; posttraumatic stress disorder; alcohol dependence; and non-alcoholic substance use disorder (Nuttbrock et

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al., 2010; Reisner et al., 2016). Furthermore, within the transgender community, male-to-female transgender (MTF) individuals were identified as the most vulnerable to mental health problems (Bazargan & Galvan, 2012; Bockting, Robinson, Forberg, & Scheltema, 2005). Elevated levels of discrimination and isolation mostly attributed to this.

Prejudicial attitudes of society have been reported to serve as a barrier for TGFs in the workplace, which contribute towards the population opting to engage in sex work as a means of survival when seeking employment (Nadal, Davidoff, & Fujii-Doe, 2014).Besides, it can be inferred that the prejudice TGFs face in the workforce in conjunction with the state of poverty in the South African context only add to their financial vulnerability. It has been found that 25.2% of South Africans live in extreme poverty, where the individuals survive on R441 per month. Furthermore, over half of South Africans (55,5%) fell within the bracket of the upper-bound poverty line, which is described as living off R992 per month (Statistics South Africa, 2017). In a survey on the transgender population in the United States, it was found that they were more likely to be living in poverty in comparison to the cis-gendered population (Crissman, Berger, Graham, & Dalton, 2017). Therefore, it can be deduced that the combination of the economic climate in South Africa, along with the barriers that TGFs face when attempting to enter the workforce, act as factors contributing towards the population engaging in survival sex work (Bazargan & Galvan, 2012; Nadal et al., 2014; Sausa, Keatley, & Operario, 2007). Furthermore, rigid views of gender identity have been found to be the source of multiple other marginalisations, including homelessness, substance abuse and mental illness (Brennan et al., 2012; Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014) which only serve to perpetuate the unrelenting poverty faced by TFSW.

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1.2 HIV vulnerability

Research conducted by the South African National AIDS Council (SANAC) on TFSW indicated a disproportionately high risk and prevalence of the human immunodeficiency virus (HIV) (South African National AIDS Council, 2017). Transgender female sex workers are a minority not only within the general population; but also, within the SW population of South Africa (South African National AIDS Council, 2013). Estimates drawn from previous research when combining a national survey predict that TFSW occupy a mere 4% of the national SW population (Konstant, Rangasami, Stacey, Stewart, & Nogoduka, 2015). Forming part of a minority group who are marginalised and vulnerable on multiple levels of society, places the

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population at risk of being structurally overlooked (Nadal, Davidoff, & Fujii-Doe, 2014) – consequentially, leaving a negative impact on their health.

The transgender population faces a 49 times greater likelihood of being infected with HIV in comparison to the general population (UNAIDS, 2016). Moreover, TGFs are more vulnerable to HIV infection than that of transgender males (TGM), as TGFs are more likely to practice unprotected anal sex (Baral et al., 2013; Brennan et al., 2012; Nadal, Davidoff, & Fujii-doe, 2014). Moreover, sex work is an additional factor that contributes towards the HIV burden that TFSW face, with 20% of new infections in South Africa having been traced to SWs (Samudzi & Mannell, 2015). HIV incidence among TFSW living in South Africa is unknown. It can however be deduced that the prevalence is high when considering the mentioned factors in conjunction with South Africa's HIV incidence. South Africa has been reported as having one of the highest HIV rates in the world (Needle et al., 2008) with an eighth of the population being people living with HIV (PLWH) (Statistics South Africa, 2017). This combined with the heightened risk of HIV infection among SWs and HIV being described as endemic among the transgender female SW population (Brennan et al., 2012). The implications of both TGF and SW identities intersecting is being overwhelmingly 'at-risk' for contracting HIV infection. While HIV is now treated as a manageable chronic disease, the HIV-related stigma remains a key contributing factor regarding negative health outcomes (Turan et al., 2018). In a study conducted in India, it was found that based on their gender identity and work, TFSW are primarily discriminated. The identities of TGF and SW subsequently interconnect that produce social inequities, e.g. poverty, work discrimination, and community discrimination – only adding to HIV vulnerability (Ganju & Saggurti, 2017).

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1.3 Marginalised identities

Sex workers living in and outside of South Africa have reported that police officials frequently commit acts of brutality, where SWs are financially and sexually exploited, arrested on no grounds and physically abused (Decker et al., 2016; Luiz & Roets, 2000; Samudzi & Mannell, 2015). These acts of police brutality are extremely unreported, as the status of sex work is criminalised and thus stigmatised, which in turn causes SWs to feel and experience restricted access to police services (Fick, 2006). The inequity displayed by society can be understood through two foundational factors. Firstly, being a TGF means not 'fitting into a set-gender', and thus disrupting society's heteronormative views on gendered binaries i.e.

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masculine and feminine (Kattari & Begun, 2017). Secondly, the criminalised status of sex work in South Africa (ACT No. 32 of 2007: Criminal Law) immediately places this population at risk of being incarcerated and contributes towards negative perceptions (stigma) and attitudes held towards TFSW. As a result, SWs are not only viewed as criminals but treated as individuals who have a criminalised and deviant identity. These mentioned factors culminate into a denial of basic human rights as well as an unsafe working environment, with resultant violent abuse for TFSW (Dekker et al., 2015).

Transgender female sex workers are a minority group and thus predisposed to experiencing minority stress, which suggests that social stressors originate from identities that are socially stigmatised, leading to impaired psychological functioning and poorer well-being among discounted populations (Breslow et al., 2015). Minority stress among black TFSW can be viewed through the lens of a quadruple minority, as the population is marginalised on the basis gender, work, class, and race; causing these women to face higher levels of minority stress (Bazargan & Galvan, 2012; Koken, Bimbi, & Parsons, 2010). Often this can result in the group internalising the transphobic attitudes that they encounter.

Transgender females face the dangerous reality of being 'physically' visible to a society that is largely transphobic (Nagoshi & Brzuzy, 2010), thus only worsening their vulnerability to gender-based stigma and discrimination, and restricting their access to safe spaces (Pan American Health Organization, John Snow Inc., & World Professional Association for Transgender Health, 2014). This visibility is only amplified through engaging in street-based sex work, as the sex worker engages in criminalised work in a public space. They are vulnerable to violence and at the mercy of police officials, clients and the general public with the perpetrators not fearing reprisal. Paradoxically, the multiple oppressed identities that TFSW hold, have rendered them intersectionally invisible (Purdie-Vaughns & Eibach, 2008), with little to no interference at a policy level (Nadal, Davidoff, & Fujii-Doe, 2014). Furthermore, it has been theorised that multiple oppressed identities have led to groups that have more than a single subordinate identity to be rendered 'intersectionally invisible' (Purdie-Vaughns & Eibach, 2008). Intersectional invisibility occurs when multi-layered intersectionalities are overlooked (e.g. race, class, gender), as a single oppressed identity can be foregrounded.

Marginalisation of the transgender female SW population further includes their criminalised work and their 'non-conforming' gender (Brennan et al., 2012; Decker et al., 2016). Transgender individuals and SWs experience a lower quality of life compared to the

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general population, which is mainly because of the dangers associated with sex work and the discrimination on multiple ecological levels that these individuals face (Bazargan & Galvan, 2012; Nadal, Davidoff, & Fujii-Doe, 2014; Needle et al., 2008; Rekart, 2005). Transgender female sex workers are a vulnerable population on multiple ecological levels, ranging from intrapersonal to policy level, resulting in extreme stigma, discrimination, and isolation (Gamarel et al., 2014). The subsequent effect of these issues often manifests in high levels of substance abuse, poverty, and the risk of HIV infection and violence (Fitzgerald, Patterson, Hickey, Biko, & Tobin, 2015; Nadal et al., 2014).

South African laws surrounding gender variant identities and homosexuality are viewed as progressive compared to the rest of Africa (Jugroop & Esterhuizen, 2016). Throughout the African continent, 34 of the 54 countries criminalise homosexual acts based on the Penal Code. Mauritania, Sudan, and areas of Nigeria and Somalia view homosexuality as punishable by the death penalty (Ricardo, Langen, & Odumosu, 2015). When viewing South Africa's legislative stance on nonconforming gender identity and homosexuality, the country could be viewed as tolerant, because of the gender and sexuality policy it has in place. The South African constitution protects the LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, plus) population from unfair discrimination based on sex, gender and or sexual orientation (Promotion of Equality and Prevention of Unfair Discrimination Act 4, 2000). However, despite the progressive laws, the South African LGBTIQ+ individuals are facing a crisis of interpersonal, community and structural discrimination. This is evident when considering those hate crimes and violence are perpetrated against the TGF community. Narratives of TFSW contradict South Africa's progressive constitution. These narratives include those of dehumanisation at the hands of police officials who abuse this population on multiple levels (Dekker, 2015; Fick, 2006).

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The South African constitution that refers to sex work as 'prostitution' (a derogatory word aimed at sex workers) criminalises sex work based on the archaic Sexual Offences Act 23 of 1957 (Nyathi-Mokoena & Choma, 2013; Radebe, 2013). The legal stance on sex work is in line with the general global legal status, which is partly based on the failure of separating dominant beliefs on sexual morality from the law. This law not only criminalises the act of sex work, but promotes the demoralising perspective that society holds on sex workers by enforcing the criminalisation of their work (Luiz & Roets, 2000), which fosters the violation of sex workers basic human rights (Decker et al., 2016). The director of the South African National AIDS Council (SANAC) made a public announcement in 2016 calling for the

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decriminalisation of sex work. It was argued that the criminalisation of sex work only worsens the stigma and discrimination perpetrated against sex workers. In consequence, this creates a barrier for sex workers when seeking health care. Street-based sex workers are more visible to police officials and the general public, as opposed to their counterparts working in indoor facilities, thereby increasing their risk of incarceration. Street-based sex workers living in South Africa work under extremely challenging circumstances and are more vulnerable to poverty, exploitation from pimps and/or police officials (Fick, 2006)

Transgender female sex workers face a set of unique challenges on individual, interpersonal, community and structural level, because of their intersecting identities of 'transgender female' and 'sex worker' (Poteat et al., 2016). The intersecting of TGF and SW identities are met with extreme discrimination and rejection from close relatives, community members, public officials and on a structural level (Brennan et al., 2012; Nadal et al., 2014). These forms of discrimination and stigmatisation often lead to a predisposition to heightened levels of poverty, HIV, substance use and mental illness (Nemoto et al., 2011; Poteat et al., 2016). Furthermore, South Africa's constitution and policy has explicitly addressed the problem of discrimination based on gender, but social minority groups still face extreme levels of injustice (Lee, Netshandama, & Matshidze, 2017). This thesis had three broad study areas that impact TFSW lives on profound levels, namely, their experiences of their families, occupations and the healthcare system. The reasoning for choosing these three areas were to gain a more holistic view on the overall experiences of TFSWs in order to guide future research, and thus, better address TFSWs specific needs.

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1.4 Aims and objectives of the study

In the current study, I aimed to explore the subjective experiences of TFSW within their families, occupations and the healthcare system in South Africa. The following objectives guided the current study:

1. To explore the subjective experiences of TFSW within their families.
2. To explore the subjective experiences of TFSW while working in the city of Cape Town.
3. To explore the subjective experiences of TFSW of accessing the healthcare system.

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1.5 Chapter organisation

In the introductory Chapter, background information is given on transgender female sex workers. Furthermore, the aims and objectives of the study are included.

Chapter two comprises a literature review, containing the theoretical framework and the most relevant research about transgender females and sex workers' exposure to discrimination, stigmatisation, HIV, poor health services, substance use, and mental health.

In Chapter three, a comprehensive overview of the methodology employed in this study is provided, which includes the research design, participants, method of data collection and procedure as well as data analysis. Ethical considerations and reflexivity are also included in this chapter.

The findings that emerged from the thematic analysis are incorporated in Chapter four.

In Chapter five, the findings are discussed by examining the results alongside relevant literature. The chapter is concluded by articulating the limitations of the study as well as providing recommendations for future research and policy.

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Chapter Two

Literature review

2.1 Theoretical framework

Issues such as racism, sexism, classism, disablism, ageism, and other forms of prejudice are not separate systems, but rather interconnected, which in turn creates a multifaceted arrangement for those who are doubly, triply or even quadruply oppressed. These identities or inequalities do not only interact with one another, but also with a system that has been constructed to oppress the majority of society. Any identity held that deviates from the position of dominance decreases an individual's power (Cho, Williams Crenshaw, & McCall, 2013). Patricia Hill Collins unpacks intersectionality in the Matrix of Domination that illustrates systems of inequality that are interconnected (Hill Collins, 1990) that illustrates how feminism based on gender alone is a reductionist perspective . In the case of an able-bodied white women are oppressed by their gender (in comparison to that of males) but experience privilege based on race. Black women experience what is known as 'double jeopardy' by experiencing oppression based on their race and gender. In the case of the current research, intersectionality not only provided a frame that could capture the challenges associated with the compounded identities of TFSWs, but also the socio-political context of a post-colonial South Africa (Moolman, 2013).

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Intersectionality is a tool that can be utilised to learn and respond to the way that gender intersects with alternate identities including how these identities intersect and contribute towards experiences of marginalisation and oppression (Morris & Bunjun, 2007). In the current study, experiences of TFSW who hold multiple oppressed identities with their gender, class, work and in some cases race. Those who participated in this study were not only oppressed based on their gender of being a woman, but furthermore on the basis that they were not cisgendered women – being cisgendered is the position of privilege (Johnson, 2013). Therefore, it was vital that the participants and their experiences were viewed and analysed through a lens maintaining an appreciation of their multiple oppressed identities, and how these socially discriminated identities permeated into their experiences (Yuval-Davis, 2007). Through this framework, a critical approach allows for political engagement together with challenging structural problems and the status-quo by speaking to the interconnectedness of gender, class, race, and sexuality (Taylor, Hines, & Casey, 2010). These categories that marginalise groups

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of people or individuals intersect with one another and thereby generate an interdependent system of marginalisation and discrimination (Crenshaw, 1991).

In 1851, Sorjourner Truth delivered her famous speech, "Ain't I a woman?" that addressed her experience of being a black female in a society where slavery was still acceptable to many.

> *That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman?*

While her context was different from that of a TGF, they too, are treated as 'lesser women' and have their womanhood consistently questioned by society.

Through the interactions of these socially discriminated identities, an interdependent system of marginalisation is generated (Crenshaw, 1991) where the population is discriminated against on a systemic, institutional, and interpersonal level (Nadal et al., 2014). The group of TFSW who participated in the study held multiple oppressed identities, such as being black while having a non-conforming gender identity – TGF, living on the street, engaging in criminalised work, and being HIV positive. These multiple subordinate identities do not fit into a single oppressed identity, and thus it is theorised that this renders the individual "intersectionally invisible" through becoming lost in the multiple intersectionalities (Crenshew, 1991; Morris & Bunjun, 2007; Nadal et al., 2014; Perdie-Vaughns & Eibach, 2008).

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2.2 Sex work

Sex work has been documented in numerous historical texts, with testimonies of it being found in some of the oldest human records, proving the demand for sex as an age-old commodity (Luiz & Roets, 2000; Monto & Julka, 2009). Sex work has been described as the providing of sexual services and receiving compensation (Harcourt & Donovan, 2005). The industry is dominantly criminalised when viewing policy on a global level, with some countries implementing religious laws where SWs who are found guilty, can be executed, e.g. Iran (Decker et al., 2016). The criminalisation of sex work has also been highlighted to lead to an increase in the levels of human rights violations faced by SWs, contributing to them being viewed as 'deviants' in society (Krüsi et al., 2014; Samudzi & Mannell, 2016). Furthermore,

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because of the criminalised state of sex work, SWs are often harassed, exploited, publicly dehumanised, physically abused and raped by police officials (Decker et al., 2016).

The sex industry operates in a variety of contexts such as brothels - an indoor location dedicated to providing sexual services; escort agencies, where the agency acts as a mediator between the SW and client, often charging relatively expensive rates; and street sex work, where SWs are picked up on the street, with the exchange of services often happening in the car, an isolated public area or a short stay on a premise (Harcourt & Donovan, 2005; Luiz & Roets, 2000). If SWs were placed on a hierarchy in relation to social class, street-based SWs would be situated at the lowest position, with the least earnings and experiencing some of the harshest working conditions, i.e. poverty, low earnings, the risk of HIV infection, occupational violence, and rape (Lazarus et al., 2012; Needle et al., 2008; Poteat et al., 2015). Transgender female sex workers have further been described, as even more vulnerable to violence, who often start doing sex work because of the discrimination that they face when attempting to enter the workforce (Nadal et al., 2014). These restricted economic opportunities are but one reason for TFSW engaging in sex work. Forming part of the SW community has also been reported to allow for greater social support, along with gender validation from male clients (Nadal et al., 2014; Poteat et al., 2015).

2.3 HIV

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Although there are no conclusive statistics about the prevalence of HIV among TFSW in South Africa, several studies have found that the incidence of HIV among TGFs is considerably higher than any other key population (Baral et al., 2013; Jobson et al., 2012; Poteat et al., 2016). An estimation based on a nationwide survey found that female SWs who are HIV positive amount to 59.8% of the female SW population (South African National AIDS Council, 2013). This is almost five times the number of South Africa's general population who are living with HIV, which is estimated at 13.1% (Statistics South Africa, 2018). Therefore, it should be noted that according to studies, TFSW are at higher risk of being HIV positive than female SWs (Nemoto, Bödeker, Iwamoto, & Sakata, 2014; Operario, Soma, & Underhill, 2008; Poteat et al., 2015).

The high incidence of HIV among SWs is a complex issue, which should not be oversimplified by the constant epidemiological link – at the risk of stigmatising SWs further, by associating HIV to their SW identity (Samduzi & Mannell, 2016). Much of the reasoning reported relating to no-condom use could be attributed to disempowerment, whether it be the

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power relationship between the SW or client; or financial disempowerment (Samudzi & Mannell, 2016; Wechsberg, Luseno, & Lam, 2006). In some instances, SWs feel powerless concerning condom negotiation as clients often insist on condomless sex (Decker et al., 2016; Gupta, Weiss, & Whelan, 1996; Reisner et al., 2013). Condomless intercourse can mean financial survival considering the high poverty rates among this population (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014). Further social issues that contribute to sexually risky behaviour is substance abuse, which lowers one's inhibitions when partaking in sexual relations with a partner or when working with a client (Hoffman, 2014). A report that participating in unprotected receptive anal sex allows for TFSW to feel validated and desired as a woman (Reisner et al., 2009) affirmed their gender.

The South African National AIDS Council's national strategic plan has listed SWs and transgender individuals as key populations for targeted intervention (South African National AIDS Council, 2017). Transgender female SWs are oppressed on a structural level because of their stigmatised gender identity and criminalised work status (Glynn et al., 2017; Reisner et al., 2013). The culmination of the previous mentioned factors can result in poor access to health care and inadequate HIV prevention methods tailored to TGFs, alongside their criminalised work (Poteat et al., 2015). Transgender females face increased financial disempowerment, as they often have low education levels , thus affecting them when seeking employment outside of sex work (Nadal et al., 2014; Poteat et al., 2015). Sex workers reported that substances allow them the confidence to perform at their job, subsequently becoming addicted in the process (Reisner et al., 2013). Transgender females are also at higher biological risk of contracting HIV, as they often engage in receptive anal sex (Brennan et al., 2012), an action that has been reported to affirm their frequently discredited gender. Antiretroviral treatment adherence was reported to be significantly lower among TGFs (Baguso, Gay, & Lee, 2016; Sevelius, Carrico, & Johnson, 2011) in comparison to the general population. Poor retention in care among TGFs has been identified an additional issue (Sevelius, Patouhas, Keatley, & Johnson, 2015) which researchers have attributed to issues such as depression, low self-efficacy and experiences of discrimination and stigma when seeking healthcare.

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2.4 Transgender female

The LGBTI+ community is culturally discriminated against by society, as this population does not conform to the "normal" cis-gender. Many African leaders view homosexuality and

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deviation from normative gender roles as something that was ushered in by colonialism. One is not considered to be a 'true African' when deviating from heteronormative sexuality or gender identity (Abolafia Anguita, 2012). This view parallels that of the Apartheid government, where deviating from the heteronormative was seen as a threat to the ideals of Apartheid, leading to the criminalisation of homosexual acts (Ratele, 2009). Police officials had the power to arrest men who have sex with men (MSM) on the grounds of suspicion, with severe penalties (Abolafia Anguita, 2012). Radical patriarchal views were endorsed by churches and schools during Apartheid, and the South African population was conditioned into believing that this was the 'natural order' (Ratele, 2009). All these cultural issues have served to increase the prejudice and negative perceptions against the LGBTI+ population, with these negative mentioned attitudes still deeply rooted in contemporary South African society (Hart & Padayachee, 2013).

Familial rejection and abuse are rife among the transgender population. This can occur at any age, however, youth are often subjected to family rejection and abuse based on their gender identity, leading to some being forced out of their homes and having to live on the streets (White Hughto, Reisner, & Pachankis, 2016). This lack of support, and violence (emotional and physical) perpetrated by family has caused many transgender individuals to struggle with their physical and mental health, in their relationships and in the workplace (Grossman & D'Augelli, 2008; Koken et al., 2010).

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Given that this population is discriminated against and vulnerable to physical, verbal and sexual violence, TGFs often avoid participating in public events out of fear of positioning themselves in situations causing further victimisation (Jobson et al., 2012). However, this method of survival may lead to further isolation from society. The discrimination and isolation are exacerbated by the fact that sex work is also an isolating profession, where the SWs often conceal their occupation from their family and community (Choudhury, Erausquin, Park, & Anglade, 2015). Sex workers are often ostracised by society, based on moralistic objectification. The perspective of selling sex is aggravated by the fact that the profession is criminalised (Kempen, 2016). In this respect, criminalising sex work further can be argued to promote the discrimination and isolation against TFSW.

According to Brigetten and Nel (2011), the LGBTI+ community in South Africa is violently targeted. The more visible the individual's nonconforming gender/sexual identity, the greater the likelihood of a hate crime being committed against the individual. TGFs are

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described as comparatively more noticeable within the communities they occupy, which increases the risk of violence perpetrated against this key population (Jobson et al., 2012). This violence can range from verbal abuse, where homophobic or racist slurs are used to physical assaults where the individual is either beaten, raped or murdered (Kerrigan et al., 2015). Corrective rape in South Africa has become a central problem among those who do not fit the criteria of heteronormative gender identity or sexuality (Boonzaier & Zway, 2016; Thomas, 2013). Therefore, this is a threat to this population's physical safety given the various intersecting factors of oppression, which intensify TFSW' vulnerability to sexual violence.

As a transgender female SW's occupation is criminalised the stigma continues. Therefore, TFSW are viewed by societal standards as not only nonconforming in gender but as criminals. According to Hoffman (2014), 59% of TGFs reported experiencing sexual assault or violence at some point throughout their lives. While statistics surrounding TFSW are scarce, it was found that 12% of female SWs in South Africa have reported being raped by a policeman (Gould & Fick, 2008) and 70% have reported being violently victimised by a police official (Women's Legal Centre, 2012).

Transgender females and SWs are severely vulnerable to multiple forms of violence, as evidenced by statistics from an American report, focusing specifically on the transgender female SW population. The research reported police officials had mistreated 64.1% of TFSW and a further 9.2% had been sexually assaulted by a police official (Fitzgerald, Patterson, Hickey, Biko, & Tobin, 2015). These statistics are very similar to the percentage of female SWs, who experienced police brutality in South Africa (Kalichman, et al., 2005; Shields, 2011). This population is vulnerable to violence on an international level. South Africa, however has one of the highest rape statistics in the world (Vetten, 2014), which would further the intensity of vulnerability to sexual violence.

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2.5 Access to health services

Very few public health facilities and public health workers are sensitised in treating the transgender community's health needs. This leads to TGFs avoiding health facilities altogether (Sevelius et al., 2011; Sevelius, Keatley, Calma, & Arnold, 2016). In a South African survey conducted on transgender access to health services, respondents reported that health workers discriminated against them when they had tested positive for HIV (Stevens, 2012). Health

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workers were also accused of referring to respondents as "immoral", and in some instances, the respondents were denied health treatment (Stevens, 2012). Further events included stigmatisation by health workers based on their SW identity, where they reported verbal abuse, discrimination, breach of confidentiality and denial of treatment from health workers (Scorgie, Nakato, et al., 2013). As mentioned above, the culmination of events caused many not to remain retained in care and resulting in them not receiving their antiretroviral therapy (ART) care, consequent to the discriminatory attitudes of health workers (Baguso et al., 2016; Decker et al., 2016; Stevens, 2012).

The extreme levels of discrimination, stigmatisation, and abuse that TGFs encounter when accessing health care at public health facilities have resulted in severe consequences (Hamblin & Nduna, 2013). Research by Hamblin and Nduna (2013) portrays the story of a TGF who was gang-raped and subsequently denied pre-exposure prophylaxis (PrEP) by a nurse, who responded to her request for PrEP in the following manner: "She snorted, told me to go home and take off my dress. We put up a fuss, but nobody cared. I went home to hide. I could not go back to the hospital . . ." (p. 58). As a result, the participant reported contracting HIV. The preceding is followed by a similar story, where a transgender female SW described being gang-raped by clients in Hillbrow throughout the night. When seeking medical care, she was mocked and ostracised by the doctor and hospital staff, telling her that she was not raped, but rather "sodomised as she is a man" she left the hospital without medical treatment (Scorgie et al., 2013).

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2.6 Mental health

Overall, the mental health and well-being of TFSW are relatively bad in comparison to the general population. These can be related to issues such as financial difficulties, community and family isolation, high exposure to gender-based violence (GBV), internalised stigma, homelessness, and poor psychical health (Bazargan & Galvan, 2012; Brennan et al., 2012; Nuttbrock et al., 2014). A study was carried out that measured various aspects of mental health among the transgender population residing in India, where results were compared with those of a group of cis-gendered individuals. Findings revealed that the transgender population experiences higher levels of anxiety, depression, and isolation compared to those who identified with their assigned birth sex (Dewan & Kumar, 2017). These findings have been corroborated by multiple studies (Bazargan & Galvan, 2012; Henry, Perrin, Coston, & Calton,

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2018b), also highlighting issues of self-esteem and stigmatisation. Furthermore, significant results were detected relating to attempted suicide among the male-to-female transgender population (Clements-Nolle & Marx, 2006).

Research conducted in America, surrounding intimate partner violence on 78 transgender individuals, where multiple cases of abuse were listed, had added to mental health problems (Henry, Perrin, Coston, & Calton, 2018a). In this article, contributing factors to mental health problems were reported as exposure to intimate partner violence (reported by 71.8% of the sample), psychological abuse (70.6%), physical abuse (42.3%), and sexual abuse (32.1%). Participants reported that these events affected their mental health negatively. Overall, the transgender and SW population faces higher rates of mental health problems than that of the general population (Goldblum et al., 2012). These can be attributed to the many adversities they experience, such as family rejection, GBV, community isolation; HIV infection, substance use as a means of coping, and homelessness (Brennan et al., 2012; Glynn et al., 2017; Tsuyuki et al., 2017). While mental health is located internally, an individual's external environment has a considerable role to play in an individual's mental state. As the literature portrays, a society that is intolerant of TGFs and SWs, where both identities are highly stigmatised, it will engender severe challenges regarding their mental health.

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2.7 Homelessness

Homelessness is directly linked to poverty, which is a prevalent problem in South Africa (Statistics South Africa, 2017). Homeless youths, who into adulthood, continue living on the street often die young, which as reported is caused by violence, substance abuse or untreated HIV (Kok & Cross, 2010). Living on the street has negative implications on the well-being of the population. In a study conducted on the health and well-being of homeless South Africans, it was found that the population was significantly vulnerable to violence and assault (physical and sexual) (Seager & Tamasane, 2010). Other difficulties they faced were substance-related violence and gang fights; ill-treatment from health workers leading to poor health; as well as substance abuse that could lead to risky behaviours (Seager & Tamasane, 2010).

The transgender individuals have a higher likelihood of finding themselves living on the street, as they are often financially vulnerable and rejected by family members during adolescence (Brennen et al., 2012; Smit & Viviers, 2016). Once the transgender person finds

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him/herself homeless, they face various challenges because of the stigma attached to their gender identity and being subjected to violence, because of the multiple levels marginalisation (HCH Clinicians' Network, 2002). Ouspenski (2013) conducted a focus-group in South Africa with 11 people who identify as transgender, with three of the participants having expressed being homeless. The range of homeless was extended periods of between 10 to 20 years. The author found that many of the participants travelled to Cape Town (South Africa), holding the belief that they will escape the prejudice and violence they had previously encountered. Participants articulated that the same prejudice and violence are present in Cape Town, within the structures meant to safeguard this population, such as shelters. TGFs vocalised experiences of sexual harassment and violence within the shelter setting in Cape Town, forcing transgender sex workers to share bathing facilities based on their anatomy, rather than gender identity. Many of the shelter employees had no understanding of what it means to be transgender (Ouspenski, 2013). It was reported that 54.5% of the transgender youth had either been compelled to leave their home by force or because of abuse, which was directly linked to nonconforming gender identity (Reisner et al., 2009). Homelessness is a reality for 48.1% of TSWs living in America according to a study which was conducted via survey across the United States and reached 6400 transgender adults (Fitzgerald, Patterson, Hickey, Biko, & Tobin, 2015). In an alternative study, which focused on a sample of 151 transgender youth aged 15 to 24 years old, residing in the United States, it was found that 43% had experienced homelessness (Wilson et al., 2009).

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The literature reviewed illustrates a population facing extreme levels of gender-based discrimination and violence, a deficient poor support system, vulnerability to HIV infection, limited work opportunities, and poor mental health. Literature relating to the TFSW in the South African context is close to non-existent. Local references were limited to either the TGF population (also extremely constrained) or the SW population. Moreover, a large portion of the literature on TFSW focuses on prevalence, with little focus on the population's personal experiences of these challenges.

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Chapter Three

Methodology

3.1 Philosophical positioning

In this study, the researcher endeavoured to gain an in-depth understanding of each participant's distinctive experiences. The current study centres on exploring social phenomena we thus selected an interpretivist paradigm with the aim of acquiring an appreciation and understanding of the sampled population's experiences (Ritchie, 2003). This philosophical positioning is based on the belief that meaning is made of human interpretation, which enables one to gain a better understanding of the world through the perceptions and experiences of the participants (Thanh, Thi, & Thanh, 2015). Also, the interpretivist position places a great deal of emphasis on the context of the research location including what that space represents to those involved in the research process (Willis, 2007).

Interpretivism is based on the ideal that there is no single truth when understanding knowledge, rather, it rests considerably on the perception of the individual who is interpreting the information (Cresswell, 2009). This approach enabled the exploration and deciphering of patterns pertaining to experiences and feelings that were shared by the participants (Cibangu, 2010). Furthermore, the multiple perspectives that this philosophical positioning engenders a broader understanding of the data and illuminates previously undetected problems that participants experience (Cibangu, 2010).

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3.2 Research design

In addition to an interpretive paradigm, qualitative methodologies were used as a form of social inquiry, which enabled interpretations of the participant's experiences to be explored meaningfully. Furthermore, qualitative methods offered a depth and richness for understanding the lives of the participants, and created a space where comprehensive considerations of the transgender female SW population's experiences within the healthcare system, their families and occupations could be brought to light throughout the process of research (Labuschagne, 2003). This process is vital when researching vulnerable populations which are often misunderstood, marginalised and stigmatised on interpersonal, institutional and structural levels (Nadal et al., 2014).

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The methodological approach is consistent with exploratory qualitative approaches and concurrently aligns with the aim and objectives of the current study, which is to gather the experiences of TSFW. The research was steered by an intersectional feminist frame of reference. The principal premise of this framework acknowledges that while all women are oppressed, the oppression occurs on multiple levels (Crenshaw, 1991). This method allows for the illumination of distinctive issues that many women face (particularly TGFs) at varying intensities, because of the deeply ingrained discriminations that exist within a gender-binaried society (Nadal et al., 2014; Taylor, Hines, & Casey, 2010).

A qualitative methodology, in conjunction with an intersectional feminist framework, permitted the sample group to actively engage, reflect and collaborate in the production of knowledge (Berg, 2004). Thus, a platform was created for participants to feel comfortable in voicing their experiences. It is crucial that the participants were provided with an opportunity to speak openly and describe what social problems they experience (Berg, 2004).

3.3 Research setting

The study was conducted at a public health facility in Cape Town, South Africa that is sensitive to the health needs of MSM. While the population does not identify as men, this clinic is one of the few public health facilities where the staff is specially trained in serving the MSM and LGBTIQ+ community. The experience of the space where the research is conducted when TGFs and SWs participate is of importance, as discrimination is aimed at both identities who experience abuse and marginalisation in many settings. The way TGFs and SWs are treated is very dependent on context and location, e.g. a police station is a dangerous space for many SWs.

3.4 Participants and sampling

The participants were recruited following sustained engagement with a non-governmental organisation (NGO) based in Cape Town that advocates for the decriminalisation of SW. The NGO hosted a group that provided psychosocial support and health services to the population of TFSW. After the NGO stopped funding the group for TFSW, the doctor and

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group facilitator used their funding to continue running the support group meetings until this too became depleted at the end of September 2017.

At the beginning of September 2017, the study was introduced to the participants after attaining ethical approval from the University of the Western Cape on 25 August 2017. Negotiations began for the institutional approval from ANOVA Health Institute, an organisation focused on HIV care and research, who have assisted these participants through some of their projects and services. As only one of the participants had a mobile phone, her assistance was relied upon for sampling – thus, using the method of informant-driven sampling (Cresswell, 2009). Respondent-driven sampling enables researchers in accessing "hidden" populations, which can prove to be challenging, as privacy is often an issue, such as the case with TFSW. In respondent-driven sampling, the researcher relies on the informants to provide a chain of referrals (Heckathorn, 1997).

Using this method brought about many challenges, as there was no direct channel of communication with participants to set up times. Many participants would arrive together (TFSW often travel together for safety reasons), as opposed to the slot that the informant provided them with, which caused most interviews to be conducted back-to-back. Data was collected on three occasions at facility in 2018:

1. 2 March = 3 participants
2. 9 March = 4 participants
3. 22 March = 4 participants

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The sample comprised 11 TFSW with an age range from 28 to 59 years old. All resident of Cape Town, South Africa and ten of whom live together in what has been described as a compound of shacks under a bridge. Bearing in mind that according to South African law, any person below age 18 years is considered a minor, the "purchasing" of sex would be viewed as exploitative and criminal according to the Sexual Offences Amendment Act of 2007 (No. 32 of 2007), thus, all the participants had to be older than 18 years old.

Inclusion criteria

All participants had to have engaged in sex work within the span of the previous 12 months. This criterion was emplaced to clarify that the participant was working as a SW. The basis for choosing 12 months is because of unforeseen circumstances that could have arisen,

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such as hospitalisation or incarceration that would prevent the participant from engaging in her occupation. The participant must have identified herself as a TGF over the period of 12 months for sufficient reflection surrounding identity, and all participants had to be 18 years or older.

3.5 Data collection

In-depth semi-structured interviews were conducted, as this method of data retrieval is appropriate in situations where the research endeavours to attain an in-depth understanding of the research question and the participants' experiences (Rapely, 2001). Semi-structured interviews allowed for space where the participants were able to collaborate through active engagement. This powerful method of data collection for women is a platform where participants can provide a personal account of their experiences related to issues of disempowerment and oppression (Devault, 1990). Individual interviews were used, rather than a focus group setting based on the accounts being sensitive and confidential in nature. Participants may not have felt comfortable engaging in conversation, surrounding personal issues of their lives in a focus group setting (Boyce & Neale, 2006). Ten of the interviews were conducted in two languages i.e. English and Afrikaans, as the researcher stated that she was fluent in both languages. This enabled participants to comfortably alternate between languages when they felt like doing so.

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Feminist researchers also attempt to level out the power relationship between the participant and researcher as well as acknowledge that the participant is an active participant in the production of knowledge (Reinharz & Davidman, 1992) This happened through the process of negotiation, where collaborative research was conducted. (Devault, 1990). Questions surrounding the researcher and the research being conducted were invited. The context of the researcher and some personal demographic details were shared.

Within feminist research, there is continuous dialogue, where the roles of the participant and researcher are less static, thereby creating a collaborative space between researcher and participant (Fine, 1994). Feminist research also requires that the interviewer is transparent about personal involvement within the study (Sprague & Kobrynowicz, 2006). The interview schedule contained ten open-ended guiding questions. The questions emanated from the literature and were shaped by the study aims, focusing on the experiences of the participants in relation to their families, their work and the healthcare system (see Appendix B).

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3.6 Data analysis

Thematic analysis was used in this study, as it has a unique distinction in comparison with the various alternative methods of data analysis and is not associated with a specific framework (Clarke & Braun, 2013). Braun and Clarke (2006) devised a thematic analysis allowed the accounts of the participants to be sorted into various themes, as this study hoped to gain an understanding of the TFSW' experiences. have devised a 6-step approach within the thematic analysis, which includes familiarising oneself with the data, generating initial codes, searching and reviewing themes, defining and naming themes, and producing the report. The study utilised thematic analysis, as opposed to alternative forms of analysis (narrative or discourse) as it searched for reoccurring themes that described the most common experiences across the group of participants.

Familiarising oneself with data

Having conducted, transcribed and translated all of the interviews, the researcher entered this stage with a holistic and in-depth understanding of the data. According to Bird (2005), transcription is a significant process of data analysis if the research makes use of an interpretive stance, which is also referred to as an interpretative act, because of the meaning which is made during the process of transcription (Lapadat & Lindsay, 1999). Thorough reading and rereading of transcripts further allowed for familiarisation with the data. This initial stage was imperative, as examining the text providing clarity in understanding the content when progressing into the stages that followed.

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Generating initial codes

The entire dataset was then manually coded, whereby a list of preliminary codes was formed through a systematic procedure. Codes were identified through repetitive patterns. All data that were extracted were coded and organised by the relevant code (see Attride-Stirling, 2001).

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Searching for themes

The codes that were generated in the previous stage were then placed into prospective themes. Several codes were interconnected, which resulted in some themes collapsing into one another. Themes were also rejected based on lack of relevance or presence (Attride-Stirling, 2001). The themes ranged from main themes to sub-themes, which presented more intricate themes found within the dominant themes. Mind maps and tables were used to illustrate the process of searching themes.

Reviewing themes

The themes that were detected became more refined during this stage. Certain identified themes which were no longer relevant, because of not having sufficient supporting data extracts, or the data within the themes being too varied, were removed. Corresponding themes emerged, while extracts were placed under different themes when they no longer linked to the theme with which they originally aligned. Transcriptions were read over during this phase and assessed whether the themes were representative of the dataset, as well as whether the thematic map is demonstrative of the dataset (Clarke & Braun, 2013).

Naming and defining themes

At this stage, a list of secure themes, with each assigned a definition that covered the quintessence of the theme was named. The data extracts placed within the themes were analysed and sorted into a logical sequence. Quotes were interpreted in a manner that illustrated their relationship to the theme (Clarke & Braun, 2013).

Producing the report

During the final stage, a succinct, stimulating and articulate report was written which described the results of the study. The extracts and examples used in this section were rich and clearly expressed the complexity and depth of the research. Furthermore, the report was constructed in a fashion that reflected the nature of the research, while having addressed the research question in relation to the outcomes (Clarke & Braun, 2013). The framework of intersectional-feminism was applied when discussing the results. This lens allowed for the discussion to highlight the impact that the various intersectionalities had on the results (Crenshaw, 1991; Cresswell, 2009).

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3.7 Trustworthiness

When conducting qualitative research, it is necessary for measures to be taken that ensures trustworthiness (Shenton, 2004). This paves the ground for more rigorous data and to increase the overall quality of the work (Oxford University Press, 2017). Four constructs were introduced by Lincoln and Guba (1985) to ensure trustworthiness within research, i.e. credibility, transferability, dependability, and confirmability. These constructs were used throughout the research process, allowing it to emanate the essence of what the participants vocalised as well as maintaining consistency.

The research findings displayed credibility, as these were consistent with the literature that is currently in existence, building on the authenticity of the research, which has been paralleled to the positivistic measure of internal validity (Shenton, 2004). The most appropriate research methods were adopted when conducting the research and aligned with the research question, the aims and the objectives of the study. The relationship built over time with the stakeholders of the institution where the research took place, contributed to building trust with the participants and the institution.

Reflective commentary was maintained throughout the research process that monitored the progression of the interviews and themes that started to emerge. The researcher remained mindful of how the patterns were discovered. Furthermore, triangulation was used where the supervisor and researcher individually analysed the data, after a comparison of themes were made. Frequent debriefing sessions between the supervisor and researcher, discussing areas of the study that may have been flawed and to gain a broader or alternate view of the research (Lincoln & Guba, 1985).

According to Patton (2002), the related experience and credentials of the researcher are particularly important when conducting research. The researcher has extensive experience in qualitative research and is a registered counsellor with the attendant skills set for working with vulnerability. This enabled for the creation of a safe space for interviews and debriefing sessions.

While sampling for this research was a complicated process, the methods were clearly stipulated and can be repeated in future studies of the same nature, thus meeting the aspect of

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dependability (Lincoln & Guba, 1985). Thus, it requires that the methodological processes are successful in serving as a blueprint.

No form of research, whether quantitative or qualitative methods has been stated to be completely objective (Morrow, 2005). This bias should be minimised where possible. In The researcher maintained an awareness of her preconceptions to decrease the presence of bias. An "audit trail" was kept, with a mapping of how the various processes and stages of research emerged and was experienced.

3.8 Reflexivity

As a heterosexual, white, middle-class female who is currently in a postgraduate programme, I remained aware of my social positioning within the research process and intersecting factors that marginalise TFSW based on class and gender. I acknowledged that TFSW do not comprise 'helpless victims', but are resilient and holistic individuals, who have been stigmatised and marginalised by a society that is built on despotic ideals. Given my personal commitment to social justice, it was crucial that I maintained my research-activist boundary intact, through keeping a personal diary and an audit trail. My investment in the research for social justice advocacy for transgender SWs required self-vigilance regarding my biases, such as identifying as a postmodern feminist and advocating for the decriminalisation of sex work. I remained conscious of the participants who are a vital part of the research process and view these women as active participants with agency. Throughout data collection and analysis, the researcher managed opposing feelings, as, she could relate to most on some level (similar age, experiences of loss) however she experienced was aware of her position of privilege.

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3.9 Ethics

Before collecting data, institutional approval from the University of the Western Cape was obtained, in the form of ethical clearance (see Appendix D) and from the Director of the health facility where the study was conducted. All participants were fully briefed about the research on two occasions, before attaining informed consent. All the necessary information relating to informed consent were provided verbally as well as in writing. Explanations of voluntary participation were provided, describing that at any point the participant was free to leave the study without negative consequences. Participants were further informed that they

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could choose not to answer a question if they did not feel comfortable. They were made aware that confidentiality would be limited, should the circumstance arise that risk was posed of the individual inflicting harm onto themselves or others. The respect and dignity of the participants were upheld, and confidentiality maintained, acknowledging the participants as autonomous individuals and recognising the participants as active role-players in the research development/evaluation. A debriefing session was held after the interviews had taken place.

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Chapter Four

Results

4.1 Overview of themes

The main themes that emerged from the analysis were: *Transgender female*, *Sex work,* and *HIV* (Table 4.1). These three themes are summarised in the quote below from one of the participants:

> *So, to be a trans, it's not a single decker; it's a triple decker of stigma you face. Facing the stigma of being transgendered, being HIV positive and being a sex worker. So now [pause], you are like a pizza. Triple Decker Debonairs. It's creamy, it's filling - one slice fills you.* - Andiswa[1]

The first theme, *Transgender female*, captures the past and current experiences of participants relative to their gender identity (as a TGF). Under this theme, the development of a participant's identity formation (*Life progressions)*; recollections of family – both biological and social *(Prominent people)*; and experiences of violence, discrimination and stigmatisation as they live out [publicly] their gender identity (*Transphobia)* are discussed.

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The second theme, *Sex work*, includes descriptions of entering the sex work industry, as a means of survival (*Starting sex work: survival sex*). Multiple types of abuse associated with sex work are discussed in the sub-theme, *"It's a dangerous job"*. Further, articulations of the participant's humanity being removed, and basic human rights denied are outlined in the sub-theme, *Dehumanisation;* and relationships with regular clients are portrayed as being a source of financial and emotional support *(Regular clients)*. Under the sub-theme, *Substance use*, participants describe how they depersonalise from the negative feelings that are associated with sex work.

The third theme, *HIV – a shared experience*, is a compilation of TFSW's experiences of living with HIV. Accounts of getting tested and receiving HIV-positive diagnoses are depicted in the sub-theme, *"I found out I'm positive"*. Barriers such as poverty, intimate partner violence

[1] All names used are pseudonyms in order to honour confidentiality

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and stigma are articulated under the sub-theme, *Challenges with adherence to ART*. The sub-theme, *Fear of disclosure of HIV status*, portrays participants' struggles with disclosing their HIV status to those closest to them. *Self-stigma* is highlighted in the accounts of self-blame and the internalisation of societal stigma related to being HIV positive; judgement from health workers while attempting to access health care is captured in the sub-theme, *Barriers to health services:* "*Oh AIDS, oh you come for TB*". The final sub-theme on *Discrimination* portrays participants being shamed and treated poorly based on their HIV status.

Table 4.1: Themes, sub-themes and codes

Main theme	Sub-theme	Code
Transgender female	Life progressions	*Reflections of family* *First knowing* *Transition to the street*
	Prominent people	*Biological family* *'Sisters'* *The next generation*
	Transphobia	
Sex work	Starting sex work: survival sex	
	"It's a dangerous job"	*Exposed - "not a real woman"* *Physical violations* *Intimate partner violence*
	Dehumanisation Regular clients	
	Substance use	
HIV- a shared experience	"I found out I'm positive…"	
	Challenges with adherence to antiretroviral therapy	
	Fear of HIV disclosure	
	Self-stigma	
	Hopefulness in the face of AIDS	
	Barriers to health services: "Oh AIDS, oh you come for TB"	
	Discrimination	

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4.2 Theme one: Transgender female

The subthemes, *Life progressions*; *Prominent people*; and *Transphobia*, are presented respectively.

4.2.1 Life progressions

This theme captures reflections of the participants where they recount navigating their life to their current reality of living out their gender identity as a TGF. Codes that relate to this sub-theme include recollections of early family life (*Reflections of family*); becoming aware of being transgender (*First knowing*); and the movement from living in their family home to finding themselves on the streets (*Transition to the street*).

4.2.1.1 Reflections of family

The participants reflected on their relationships with family members while growing up. A range of experiences with family members was described from familial neglect and estrangement to unconditional love and acceptance of their gendered identity. Some participants recounted experiences of family life as a dichotomy of acceptance and rejection. Rejection presented as an absence of emotional support and family isolation, where a family member actively chose to avoid some participants. The mentioned lead to participants detaching themselves from family members as a defence mechanism.

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> *As a transgender, my father didn't like it. I grew up, though, with a grandma. A grandma that was like my mother, she loved me a lot and accepted me for who I am. The rest of my family didn't accept it and I was bitter with my family, bitter with my aunts, bitter with my uncles, bitter with my nephews…their attitude changed. They never like* [have] *been there for me, like always when I need them, they like rejected me. When I called them, their phone will go on voicemail…I never took note of family, like I knew in myself if I care about them, I'm gonna be depressed and I'm gonna kill myself. Like I never worried what they say, what they think, what they do. I told them to back off and I live my life how I want to, and I never let people control or change me*. - Rose

Family rejection sometimes presented itself in the form of the pathologizing non-conforming gendered identity. The participant describes her family taking an approach where they attempted to remedy her gender identity (through psychotherapy), rather than acceptance.

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Growing up something I'll never understand, something that my mother [and] *them did never understand… At a later stage, it became a problem towards the other family that there is something wrong with me and they had to take me to a psychiatrist and it was when I was about 11… It affect*[s] *me because I was wondering, "why must I go to a doctor?" ... it took 3 years in and out, in and out and at the end of the day it was just a simple answer: There is nothing they can do about that, they just had to accept it*. - Gretchen

An acceptance-rejection polarity was found in accounts of family members using the South African slang term, *Moffie,* which, according to the Collins Online Dictionary (2018), describes "an effeminate or homosexual man" (often used in a derogatory manner). The same term is used in two differing contexts. In the first instance, to show love and acceptance, and in the latter instance, to label her as an outcast or outsider:

When my mother and father were alive there was no problem, because I was always Moffie-rig [Moffie-like]. *My mom always called me her Moffie*. - Brigette

Because I was unemployed and my gender on top of it and because of that she [sister] *changed on me, she was always shouting at me: "don't you have a job, you Moffie!"*. - Brigette

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In contrast to the reflections on harsh family experiences, there were also some accounts that depicted relatives who were caring and in acceptance of the participant's gendered identity. The presence of family acceptance and positive regard is depicted below. Nevertheless, the aforesaid did not result in participants successfully integrating into the family unit, because of a combination of feelings of shame related to their sexuality and gender; and drug use.

She [mother] *and my father also accepted me -and my sister -and my sister! She's so over me. She told me, anytime I can go home, but I don't want to go home you know? Like, hmm, like a month ago she was also here - so she said I must come home, so I said no wait if I'm better I'm going to come home… she love*[s] *me, but even - even her children -yoh* [whew]*! You know, even if I go with* [pause] *like the children are big also now, but when I go out with them yoh. Sometimes, I'm so ashamed, because I'm gay and I don't want to go out with straight people you know?* - Rebecca

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Family devotion is sketched with the central feature being allegiance and loyalty:

They [biological mother and brothers] *accepted me … if somebody else was saying Moffie or… they will fight for me, they will hit that person*. - Jackie

4.2.1.2 First knowing

Individuals' experiences of 'first knowing' their gender identity of TGF was described as a process rather than them having an epiphany or moment of realisation. For most participants, this stage of identity development took place during adolescence. Recollections of how the participants transitioned from their socially allocated roles of young boys to TGFs were illustrated in the behaviours of playing with 'girl's toys', spending time in the kitchen or performing chores, and dressing like a woman. Assigning of identities like *'Moffie'* to themselves allowed for meaning to be ascribed to the feelings, thoughts and behaviours attached to experiencing the gender identity of TGF.

Identifying as a girl was depicted as taking a preference to 'girl's toys', with further articulations stating that there was congruence in gender identity from childhood up until the present day:

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I have been this way from little, so how can I say? When I was little I loved playing with dolls and I always cried for dolls over cars [laughs] *I wouldn't say I found out at a late stage… I grew up just as what I am today… I believe I grew up like a girl, understand? I have always felt like a girl*. - Brigette

Participants placed emphasis on defying gender norms and stereotypical roles that are traditionally related to young boys. The account below contrasts the participant's behaviours to that of her brother's which was evidenced as her being the only sibling who assisted their mother with cooking and household chores as a child. In late adolescence, this manifested in the participant altering her appearance.

We were boys… Hmm, I was always the one that will help my mother at home. Washing the socks and on a Sunday. She likes to bake cakes and such things for us and I will help

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her. But when they got to high school, especially after school my hmm… I was relaxing the hair and putting on the rollers… - Jackie

Recollections of dressing up in women's clothing were depicted as part of understanding the participant's gendered identity. While one participant felt that she had to do so in secret, another felt comfortable to dress like a woman more openly.

The time that I was 12, 11 [years] *I started to try on my mother's heels in my room at night and stared at myself in the mirror. I had a long mirror. I tried on my mother's coats and jackets that could button closed* [up]*, and I saw myself as a… the television showed prostitution. I looked at myself and put a headscarf on. Then I wondered at myself and said to myself, "this is who I am, this is, this is. I feel comfortable in these clothes of hers"*. - Leanne

Since I was small I always played with my mother's clothes and shoes and stuff, because you know, you know 'mos' [of course] *a mother. She knows. Since I was in school also, she always, you know, she did know*. - Rebecca

Participating women described themselves as being known as '*Moffies'* when growing up because they did not know about the term, 'transgender'. *Moffie* is a term that originated in South Africa, as a result of the toxic masculinities formed during Apartheid, which is used to depict an effeminate male or a male that is 'lesser than' (Ratele et al., 2014).

I was very feminine, say at the age of 11, 12, but I didn't understand the word, transgender. I told myself I'm gay. I didn't know about what is transgender, what is, what is hmm MSM. I didn't know that time, just I'm gay. I would say I'm homosexual, I used that also. - Wanda

"*Back then they would have called you a Moffie"*. - Rebecca

It was just that my female hormones was [sic] *more than my male hormones and it wasn't like, trans was not in then anyway. It was just like a Moffie*. - Gretchen

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4.2.1.3 Transition to the street

Family abuse and rejection were voiced as owing to participants' adopted gender identity, which often proceeded into them having experienced homelessness at some point in their lives. Transitioning to the street allowed them to escape the dreaded realities of rejection and gender repression that was experienced at home, thus offering 'a home away from home'. However, living on the street gave occasion to new challenges of coping with the harsh realities of street life.

> *Due to that, my daddy never accepted me. He rejected me the time he discovered. I didn't just come out of the closet at home, I had to run away, to go on the road and stand on the road. To be homeless and dress myself up as a homeless, and be homeless, and then I started to show myself in the road…because I couldn't do it at home. They came looking for me, they found me with dresses* [a dress] *on and then they take*[took] *me home, they cut my hair, he hits* [sic] *me, because why am I dressing in women's clothing and I just run*[ran] *away again. Until he just accepted and said okay, if that's how I wanted to live, then I must just one time stay away, so I stayed away*. - Leanne

Identifying as a TGF was indicated as being a barrier regarding employment, with some participants reporting having relied financially on an accepting and affirming relative. Moreover, living on the street ensued from the death of such a relative with whom they resided before being homeless and who acted as a buffer during family conflict.

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> *It's since my sister and brothers, how can I say? They became funny that I did not work, and that I am how I am* [TGF] *… My mother and father always understood what I am* [TGF], *understand? And that I did not work because of what I am. Because I was unemployed and my gender on top of it and because of that she* [sister] *changed on me, she was always shouting at me: "don't you have a job, you Moffie!"*. - Brigette

> *My grandma, she was always stand* [always stood] *on my side,* [if] *anything happens she* [would] *always be there for me and talk* [stand up] *for me. My father never liked it…So, I move out from*[of] *the house and because the piece is missing* [death of grandmother] *and like my family like they are on top of me, and we fight you know and I move*[d] *out. I come* [to] *stay on the streets and that stuff*. - Rose

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The intersection of identifying as TGF along with being homeless is described as challenging. Also, the question of safety is described as an underlying hardship associated with homelessness that often leads to illicit drug use to assist in coping with the fear of the unknown dangers. Guidelines relating to surviving street life were expressed, where the meeting of basic needs are foregrounded.

> *Ja* [Yeah], *as a homeless trans hmm it's hard because why, especially when it comes to, when it comes to at night time… I guess this* [is] *also something that pushes us to substances, to drugs, because why; you are so* [pause] *you get, you build up that fear, of not knowing if you going to wake up tomorrow morning… You can't just go stay where you feel is comfortable. You must really be sure that this is a comfortable place where you* [are] *and you feel this place that there is enough safety for you around* [sic], *that you can look out for each other. Otherwise to be homeless it's sometimes hard, but it's something that you need to work on by yourself, because why, there's a lot of things you need to think about: your safety, how you*['re] *going to eat, how you*['re] *going to live, how you*['re] *going to go around to keep yourself clean.* - Gretchen

4.2.2 Prominent people

Three groups of prominent people were linked to identifying as TGF, i.e., *'Biological family'*, *'Sisters'*, and *'The next generation'*. These codes are discussed below.

4.2.2.1 Biological family

Family members were frequently described as absent or abusive towards participants – predominantly during adolescence. These traumas occurred in an already challenging developmental period that is pivotal to gender identity formation, particularly for transgender youth (Grossman & D'Augelli, 2008). Impaired parenting in addition to a lack of family support only added more uncertainty to this tumultuous period of adolescence, which in turn led to many seeking 'family' outside of their biological or household family. An example of the experience of instability during childhood and adolescence is depicted as follow:

> *You know - hmm my mother, my biological mother, she was young when she had me, but, she was, I was her second child, I am a second child, so she was still young she had a*

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child before me so a family, and she come with me, pregnant again, her family has, had through her out, she must-you know 'mos', young, so she was like, all by herself, so young so she was like, moving around doing stuff and drugs when she get me, she was involved with different stuff, people-wrong people and so, I was about 3 years old, she [pause] they put me in foster care, cause she was like umm into drugs, he would sell drugs… she went to jail, she was in jail. She went to jail, because she was with the wrong crowd… uhm, and then, three old I went but I because, of her uhm, they didn't sign me off for adoption, so when she come out she could get me again, you see, so she took me when I was like 6 years old, so I was like 3 years by this foster people fostered me in Elsies River, nice people, I was like enjoying myself, it was my first year of school I was with them, and then she came out, so uhm at the time it was the coloured affairs social services called 'mos' coloured affairs hmm so, yeah social workers did [pause] they fighting that she get me again, see if she has rehabilitated after being in jail, you see, maybe she did better to get a job, she did get a job, but [pause] *old habits came back, so we, when she get me we stayed in Bonteheuwel with people who did sign actually out for her, you sign to come out, signing social services, but these people were-were selling drugs, so she-she got back on stuff, so* [long pause] *and then again, she just left me there with the people. So, I was staying with this* [sic] *people, and, while I was staying with these people, I was like* [pause] *too many things that had happened there, but, I went to high school and I finished my matric. The last day of matric, because of things that happened, I ran away from the house and I come and stay* [sic] *on the street*. - Nancy

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Similar to this quotation, many participants reported growing up with parents who used substances and had addictions (like gambling), which contributed to family neglect and estrangement.

My father is like an alcoholic, my mother is like someone that, like she don't [sic] *care. She's like one of those lesbians, she was a lesbian. She used to gamble a lot you know. Now hmm, that's why I just went apart from the family… I never had love. There was no love in the family*. - Deidre

Some participants described their home situations as places of violence and physical abuse.

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My father used to physically abuse my mother in front of us and she never spoke about it to her family. I was the one who used to phone my mommy and said "he's hitting my mommy, he's hitting my mommy…" The last time he physically abused me was when I was [in] *Grade 10. That was the last time that I allowed him to touch me*. - Wanda

4.2.2.2 'Sisters'

The group of 'sisters' shared social identities of TGF and SW. Because of their shared experiences of family rejection, stigma and discrimination, and surviving together, they cultivated a deep connection and understanding for one another. Some of the women referred to their network of 'sisters' as the 'sisterhood'. The sisterhood was comparable to a family unit which served as the main source of support, and reported as a trans community, seeking to rebuild their family relationships in reaction to the rejection from their biological family.

I do stay around a few trans' where we build our own community, where we build our own sisterhood and- where we can talk amongst each other. If something, if we got a burden then that's one that you can talk [to] *that can assist you if you, if you want to go to a clinic then you don't have to go alone. We're building family relationships up again, because some of them are rejected by their families due to the fact that they are trans and it's hard, because why at the end of the day: Who do you face? You have to face yourself and your family alone, you can't face nobody else. Ja, and that is how we build our sisterhood community where we still get stigmatised and labelled through community bylaws, but we seem to overcome that, we doesn't* [sic] *upset us or me so much anymore, because why? I will always be there*. - Gretchen

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Facing the same difficulties was described as a powerful factor in forming a sense of unity. Andiswa provided an analogy wherein she explained that the strength of a family bond did not rest on biology facts, but rather on people who were accessible and supportive. A universal connection among TGFs is described - where regardless of geography, there is a bond that exists.

Look at this scenario, at times they say they do not have your blood type, right? And it becomes problematic for you to get that blood, but there's always water. You can buy water. So, you create a family with people you co and you meet. Not biologically related,

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because those who you are biologically related with are the ones who hurt and tarnish your image as well, because my family that [sic] *I am biologically related to… I don't think I can say a lot about them. because a trans will know my problems, I'll know their problems, we're like that. We're family. We're not biologically related, no, but we stand for each other. My family will not stand for me that I am blood-related with* [sic], *but I know trans will stand for me. They know me better than them and they know the same obstacles and it can be a trans that is in Nigeria, Angola, wherever. Same. We relate the same. The abuse, the same that we face. The molesting when you still young, the same*. - Andiswa

The familial bond that is shared by the 'sisters' is one of deep commitment, where the participant describes how they alone will support one another as a family, through illness and live out their lives with one another.

Also, I can - whatever we need, we can ask each other. Ja, we [are] *very cattish to each other, that's always the issue… If you can't walk and you don't have the energy, tell us because some of us we have cell phones and we can make a phone call and call the ambulance, because that is what I want from you guys. Is your family going to run for you? No, because why? They don't accept you for who you are, so we are family, we are standing as one and we going to run, we going to bury each other. - Wanda*

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Sharing the task of surviving together was brought to attention, which included sharing shelter, food and clothing. The 'sisters' also act as protectors to one another.

When there's problems and someone wants to hit you or something then we stand up for each other. If someone gave you a bag of clothes, then you share with each other and food we even share with each other… My sisters under the bridge, that's real family, because we stay together - we do everything together. - Rebecca

A common experience among this population rests on the notion that organisational help is only temporary, further strengthening the commitment among the 'sisters', and the trust they place in each other.

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It's the girls, no one [else], because as I said, there's no other support that we - as I told you - go back to these people, these organisations, they think that they are helping, they say that [they're] *there for you, they do, I'm just giving this and all of a sudden, there's nothing*. - Nancy

4.2.2.2 The next generation

Participants vocalised hopes of impacting the lives of the next generation of TGFs positively. Through their actions, they wished to prevent the next generation of TGFs from facing the same adversities and obstacles that they have. An adoption process was further described, where older street-based sex workers, who identify as a TGF adopt young and homeless ones. The adoptees are subsequently given their transgender name by their adoptive transgender mother.

It will be there for all the years that's still to come with a new generation, that's why we as the elder generation must pave the way. I always said, I build a legacy of myself for the next generation to come so I don't know what the next trans' is building because why at the end of the day people can talk about me and say, "At least that bitch did something wrong or something right for us in order for us to access this or access that." - Gretchen

I know not next year, or in ten years, or in twenty years, but maybe [in] *the* [next] *30 years it will be a better life for us transgenders, and a better future for the youth, so they don't experience the same as I did. Also, they must not follow the same structures, or them running away from home, because of acceptance. I want organisations to be open for them - it is not safe. Giving them good jobs,* [a] *better future for them. I don't want other trans to make the mistakes I made*. - Leanne

The process of being adopted by a transgender mother and later becoming one is described below. The role of an older TFSW regarding the younger generation is explained as naming them, providing them with advice about their health, helping them financially, and keeping an eye on their welfare and safety. The community communicate with one another in a language, *Gayle*, which they share.

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One of the older sisters who in that time adopted me with the name, we normally get adopted by one of the elders… So, if you come out of the closet then I will give you a name, I recently gave some - another transgender [youth] *a name, I gave her the name Cassidy… Recently there came two or three transgenders, who left home, and they are between the age of 17 and 18, one is 16. People don't accept, because the family don't* [sic] *accept them, that's why they left home. I'm trying to communicate with them, because they don't live where we live, because where they live is quite far, but I will go check up on them once a week in the evening while I'm working. I'll go there and check up on them and how they* [are] *doing. I will tell them if they're ever ready they are more than welcome to stay under the bridge, because that is where all of us, all the girls are staying, and I got them last night and she asked me for a Rand, and I gave her a R10 for her to go buy something. They so young and I told them you don't let the guys here, the gangsters, the other skarrelers* [thugs/hustlers] *take advantage of you and if you have sex, condomise. Ek sê vir hulle* [I tell them] *in our language, the Gayle, in the language that the trans speak*. - Wanda

4.2.3 Transphobia

Incidents of discrimination, stigmatisation, bullying and hate crimes were perpetrated against participants, which was linked to their gender identity. These human rights violations were reported for health care workers, police officers, learners and the general population. Some of the previously mentioned social actors would conventionally be aligned to safety or offering support. According to some participants, stigmatisation and discrimination by health workers was a barrier expressed when seeking health care. The discrimination manifested in the form of mocking participants in the health facility, because of their feminine presentation.

Ja, it's a lot. It's like when you get to the receptionist, then somebody will maybe call another one because you've got maybe a skirt on or still got makeup on, but it's maybe an appointment, but then forget the one that's sitting behind the desk. I'm a trans, but what makes him better… [I] *come for my only health care. In order to protect myself, I would need to look after my health. Then they start chatting to each other and that makes you feel uncomfortable, now you have to go from places* [sic] *to place. Now maybe one day you've just had it, now you go to the staff nurse, now you tell them, but then there's no way that you can win, because why? His staff or her staff is doing nothing wrong… it's a barrier because why it always keep*[s] *a person. What would happen if I get really*

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sick and I have to go to a hospital? Then I will 'mos' die. To face all those people and the stigmatisation. Why can't they accept someone who just want[s] *to be normal? We*['re] *not crazy, we*['re] *normal people like everyone, like everybody else. I guess that's part of life that we as trans' have to face*. - Gretchen

An experience of the aftermath of rape is described. Doctors and hospital staff minimised and invalidated the participant's experience of rape, adding to her distress. She left the hospital, without receiving any medical care:

I was once raped… The guy needed to pay so I went to open a charge and I was referred to hospital. From admin, they [had] *done the work because I was in drag and when I got to the doctor the doctor said "you're a man, you can't be raped. Go back, reopen your case at the police station and open a case of sodomy, because you're a man. You can never be raped, you are sodomised." And I thought from a health care provider who is a doctor, telling me that* [pause] *and I had to leave the hospital, can you imagine what it was like? And all that attention was on me because nurses from other wards were being called in to come see this clown. … and at that time, I said, "okay, I'll go, doctor. I'll go to open a case of sodomy." And when I left that hospital, I told my friend, "come let's go home." And I never went back*. - Andiswa

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Transphobia was further described as being enforced by police officers, who often abused their power to sexually violate and mock the participant based on her gender identity.

One day I was in Woodstock and I was on my way to SWEAT. I was with this guy, I know him from on the street. So now a van comes, we were at the station next to the road at the railway line and here they stop so this lady come[s] *and then they must now 'dinges'* ['whatchamacallit'], *search him then everyone want*[s] *to make a mockery, now they said I must maar* [just] *get in the van, they must take me to the police office so they can search me properly. Now I'm not scared, I 'mos' knew I've got nothing on me and so, but when they got there, there was… I don't know if it was their tearoom or what, but in the back of Woodstock police station, there was a room where they took me in. There was* [sic] *other police officers, now I had to undress me* [sic] *and they*['re] *'mos' now making a joke out of me*. - Jackie

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Police officials not only invalidate the transgender female's gender identity by placing them in male cells, increasing the risk of physical danger. Furthermore, it was stated that police officials encourage inmates to rape transgender females.

> *Ja, you get raped. You get abused by the inmates because maybe it's 10 inmates in a cell and you as a trans get thrown in there and they shout, "Okay there's meat for you" or "a wannabe woman" and then some guys for them, it's like they enjoy it… They just throw you in by the males and luckily there's sometimes a few good males, you know that you don't have to - that you don't have to fear and then there's sometimes that you don't know anybody, because why - you could just. If you have to stay over for the weekend to go to court and you have to stay over in the male cell, anything can happen, because they can just wake up and they can start, and somebody want*[s] *to creep up on you and want*[s] *to rape you*. - Gretchen

At school, 'faggot', a derogatory term used to describe a homosexual male was adopted by learners to bully the participant. The use of this term indicates the ill-understanding that the learners had about the 'transgender female' identity, by associating it with sexuality. This bullying had severe ramifications for the participant as she was eventually expelled from school for retaliating.

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> *I fought at school because they told me I'm a faggot. Then I fought at school and got expelled*. - Leanne

By not fitting into a gender binary, the individual is viewed as abnormal. Gender variance is, in turn, treated as a variance from that of 'humanness', resulting in the individual being socially positioned as 'lesser' within society.

> *Ja, and as trans people, people tend to take advantage of us, that you are not normal, you are not human enough. You're not man enough, you're not woman enough. You are a reject to society*. - Andiswa

Transgender individuals were indicated to face physical and verbal abuse that is not experienced by heterosexual individuals. Furthermore, isolation at a community level was experienced by some because societal acceptance reportedly rests on being straight.

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They will call you a lot of name[s], when they know you are transgender - they will call you a lot of names. When you are gay they will call you lots of names. They will like, throw stones to you [sic]*, like a straight woman, a straight man, they won't do that, because she's like - I need to be straight for the community to accept me, I need to be like a straight lady, I need to be like a straight guy for the community to accept me*. - Rose

After a member of the general public became aware of a participant's non-conforming gender identity, a violent act of transphobia was committed against her resulting in serious bodily harm and endangering her life.

It was [a] *long time ago, so I, someone like… When they found out I'm a Moffie, a transgender then they threw me out of the train… like under a pavement and this whole, this whole part of me* [pointing towards the right side of her body] *was like* paralysed. - Rebecca

Transphobia is described as the denial of fundamental human rights and access to public services, thus causing a participant to feel like 'less of a South African citizen' based on their exclusion and isolation from society.

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For me to live on the street like this, I got, you got stigmatised as a transgender every day. You face stigma, but to know that your safety or your life is not yours anymore. Your life, your life, hmm, is in someone else's hands. He or she can do whatever they want with it and you know there's no hmm, hmm, support system. There's a police station but not for you. Only for straight men or straight women. Who are, who am I then? Where do I fit in? I am also uh-uh-uh [stuttering] *South African citizen, but when it comes to* [a] *support system from SAPS I'm excluded*. - Sammy

We call it pinball, because why? You go from police to one [another] *police to one* [another] *police. So, what's the use of making a statement, what happened to your human rights? Do you understand? So, it doesn't give you that courage to go to a police station and face all that shit*. - Gretchen

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4.3 Theme two: Sex work

Sex work has been described by many participants as a means of income for survival, with participants' accounts of first engaging in the industry during times of desperation (*Starting sex work: survival sex*). The dangers that sex workers face while working were expressed in the theme, *It's a dangerous job,* and followed by the sub-themes, *Dehumanisation, Regular clients,* and *Substance use* which is associated with the work.

4.3.1 Starting sex work: survival sex

The phenomenon of engaging in survival sex was described by many participants as the last option to meet their basic needs, introduced to them by other TFSW. Marginalisation leading to survival sex included the onset of homelessness, unemployment, the lack of a support system, and only ever engaging in sex work as a means of income. Survival sex was introduced to the participants through a network of friends. Deidre explains that she was left with no alternative. Her narrative shifts from a stance of disempowerment to her enforcing her authority on potential clients.

> *I started to notice a group of friends. A group of hmm, hmm transgenders who were all just living on the street and they were doing all these things to get money- so I had no choice. I was like saying, "sex working does pay, imagine", because I used to, I used to, I used to have sex with guys, but then I found out about sex working. My friend Coco, he told me about it. Then afterwards I started telling guys, "No you can't have sex with me, pay me first!" Ever since then guys pay me for sex.* - Deidre

A similar experience is provided, where the participant was at first unaware that she was engaging in sex work. She only made an active decision to enter sex work after she had unknowingly engaged in sex work and was paid.

> *I come* [to] *stay on the streets and that stuff and I meet new friends - transgender friends and everything. And like they told me how to live and ja, like I remember one night - I never knew that I'm doing sex work. I had sex with this guy and this guy pays… It was my first time in town, but I told myself for what is this? And the second time it was* [like] *the same thing happens. Then like I'm meeting with my friends and I'm telling, I'm asking them, "what is that when a guy has sex with you and gives you money?" They told me*

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this is the exchange, this is sex work and I told myself it's fine, it's better like that… To let myself live my life. - Rose

Another entry point into sex work was joblessness, with sex work being described as a means of making quick money.

Hmm, sex work, when I lost my job. So, at night I meet my friends, so they say, "come, come with me to [stops talking]*." So, I thought I'm going to go with them. There's a place in Cape Town they call it the Cheap Corner. I decided okay, I'm going to make it, take it. To try it and okay one client ask for me and say, "do you want to do business?" So, I said, "yes" and from that time I'm into this business… It's a normal corner that only make*[s] *the sex cheap because of what the girls ask like R20, R50 you know?* - Rebecca

For some, sex work was reported as the only work in which they had ever engaged, putting them in a situation that forces them to continue engaging in this work for survival.

4.3 "It's a dangerous job"

All the participants experienced or witnessed physical, sexual or emotional abuse that was directly related to sex work. The sub-themes comprised instances where clients find out that they were TGFs (*Exposed - "not a real woman") Physical violations*, and *Dehumanisation*.

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4.3.2 Exposed – "Not a real woman"

A persistent danger that the participants reported facing while engaging in sex work was the threat of being 'found out' that they are a TGF, as opposed to a 'real woman'. Clients were reported to use this vulnerability to their advantage, by refusing to pay once they had engaged in sex.

Ja, say with clients if they will accept you for who you are because I mean, everybody knows, knows these days what is a transgender, [sic] *you know. They know you*['re] *a transgender, but they*['re] *so spiteful with that they do, you know? They take your, they take your money or something… They can 'mos' see this is like a man, you know, but ja*. - Rebecca

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The severity of being exposed escalates to a more serious threat, where being 'found out' by a client can potentially result in death. Furthermore, the combination of being a sex worker and transgender is highlighted as a potentially fatal risk.

> *There's a lot of us, you know, when that guy first finds out you*['re] *not a girl, then that might end as a serious problem because if they discover you've got a penis, then some will kill you; some hit you. So, it's, your life, you actually take a risk with this work as a transgender*. - Rebecca

> *I can only thank God I'm still alive, for all the things I've been through. Especially sex working. Sex working, guys abuse you, they sex you without even paying you, fuck you without even paying you. They hit you. They find out you not a real woman, hmm guys like lock you up in a room and he was like finding out I'm not a real woman. Like beating in the room. The other one, I was driving away with him in the car and when he came like out of town then he just discovered I'm not a woman. He started pinching me, smacking me*. - Deidre

A tension is described between making money versus safety, where participants, to not lose a client sometimes withheld the fact that they are transgender. Regardless of the risk associated with not disclosing, participants chose to take the gamble and compromise their safety.

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> *The work that I'm doing it's also another complication, it makes me. Sometimes clients don't know you are transgender-they think you a woman, and you have to tell them to be on the safe side, but if you tell them then they*['re] *going to be disappointed and they don't want you… So, to be on the safe side, how can I say?* [long pause] *To be on money's side you don't tell them, but it's dangerous not to tell them because when they discover you they*['re] *so furious that they hurt with the intention to get blind, cross with the blindness in front of them. They can kill you also because you*['re] *playing with your life… It happened twice; three times; four times to me, but to be honest with you I don't tell the guys because you*['re] *telling them then they take the money back. Sometimes I survive, sometimes I don't. If I don't survive, I try my best to break through it with a convincing speech. Trying to convincing* [sic] *you, there's* [a] *first time for everything or saying, "Maybe there's* [sic] *things that I can do what your wife can't do" and stuff like that.*

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You understand, to convince you, "I'm going with a trans" because some guys they['re] *negative with the trans, they don't like trans because they say we*['re] *bad luck. That's what they say, I don't know*. - Leanne

By deviating from the standard rules related to engaging in sex work has placed the lives of some participants at extreme risk. Strict boundaries allow the participants some form of safety in an unsafe working environment.

There were times when I was lucky when they found out, but I was nearly killed… I was picked up by the client in [sic] *Voortrekker road. I really don't know what happened. Usually, 'mos' I went, and there was a shebeen* [informal liquor store] *in my street, and I usually buy me a bottle of white wine and go to the street. I can't remember if, I don't know what happened that I was discovered so easily, because first of all I was picked* [up] *in Voortrekker Road and secondly the client settled for a blowjob, but then I allowed him to drive with me to Killarney's Bush and you know what they say, "Don't mix business with pleasure". I don't know what happened, I went with the guy to Killarney and how can I allow him to touch me? I came to my senses when he was hitting me, and it was quiet- and the blood was going, and he said "I'm going to kill you" ... I jumped out of the car, I was 'mos' now discovered in the car. Then as I was running in the street bare feet, he came to me and said, "I'm going to kill you". But he comes to me, but if I am on that side he comes to me, but I was so lucky because there is a light and it was the security hokkie* [cubicle] *that was there*. - Jackie

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4.3.3 Physical violations

Being physically violated was commonplace for the participants with many reporting violations made to their physical body of sexual or violent nature. Regardless of the measures that sex workers emplace to protect themselves, the sex work industry remains a dangerous one. Here is an example of a violent robbery and attempted rape.

I'm sometimes so disappointed what I have in life that I think to myself I should rather just kill myself, then I tell myself "no man, Mr right will come". I was robbed by probably two or three men, look here [shows stab wound]. *I was being attacked by two guys, hmm that approached as clients, the one only. I got in the car we were going to my spot…*

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When we got to my spot, I said, "money upfront before pleasure", he gave me my R100. While he was taking his pant[s] *off, I was taking the condom out and masturbating him then I had to give him oral sex. While I was going down with my head giving him oral sex someone just pushed the back seat to the front from the boot and jumped out. They almost raped me but all thanks to God that I break* [sic] *through. I crack*[ed] *the window with my elbow, so I threw myself out the car… I had a skirt on, they break* [ripped] *my skirt. I had a wig on, they took my wig and they grabbed my bag. It was two coloured guys, but hmm they stabbed me, but thank God I breaked* [sic] *through. I came, I came self at home, understand?* - Leanne

Another form of traumatic experience took place when the sex worker is lured to a place under false pretences, where they would be ambushed by multiple individuals or forced to have sex with all of them.

Most of the time it's not safe to do that, because when you get there, you did meet you met one person but when you get to that place, they are maybe five or four. You only maybe get paid for this one guy that you met, but all four of them are going to have sex with you. So, they force themselves on you, and that is rape, and there is nothing you can do about it and for the fact that you are trans on top of it. They did know that you are transgender, but it's like they want to cover themselves with - with the fact that, "ja, we thought, we thought that you were human and now we gonna do whatever we wanna do with you" and you also got beaten up. Without any pay. You lucky if you get something out of it… it once happened with [sic] *me here at the beach. Then there were five men* [pause] *I, I was, they did tie my hands. They did tie my hands and my-my-my feet, and they were four guys, and so I was raped.* - Sammy

A scenario similar to the abovementioned is illustrated below. However, the participant describes that the ambush and physical violence perpetrated was of a corrective nature – "to make a man out of you".

You don't know what's going to happen - sometimes they come alone and at the end of the day they drop you at a friend's place. A friend's apartment, and when you get there, there's [sic] *maybe four or five guys and there's the time that the stigma and discrimination begin because they hit you, they abuse you, they kick you around because*

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why - you['re] *not a real woman. So, in their way it means like, they want to make you a man out of yourself, by beating you, like hitting you and a lot of trans women do not make it out of a fight like that, but a few of us, we survive. It's just about getting you and your brain to thinking just about protecting yourself and how to find a way out of this*. - Gretchen

Sexual exploitation by police officials was but one of the many ways in which police misused their power against sex workers.

No, there was a [sic] *quite a few of these times here in Sea-, in Greenpoint; they were picked up, and you need to do them a favour, or they want money, or they want a blowjob in order for you to be released. Or you get picked up and thrown in the cell, the cell with men here in Greenpoint, and until maybe there's maybe one good policeman that will let you go because there's no charge against you. But you are thrown in with men, and there's also some kind of way that they also have fun with you, policemen. As I say, sex worker, sex workers got* [sic] *no rights*. - Gretchen

Police officials have been known to search sex workers on little to no grounds; searches often progress into the sex worker being made a public spectacle that includes degradation, and violations of a physical or sexual nature.

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They beat me. Physically beat me. They'll search me, undress me naked. They'll hit me in my stomach, and they'll tell you, "Shut up", talk to you like you have no right. They'll search you out in public in front of lots of people. They insult you, even if you['re] *standing on a corner talking with someone, they'll stop and search you out in the road. Even when you go to the police station, if you come by the police station, they make a fool of me. They like hmm, it's like they*['re] *laughing at you like you're a clown*. – Deidre

4.3.4 Intimate partner violence

Participants recounted the abuse they faced in past relationships with intimate partners that came in the form of manipulation that led to exploitation, along with physical violence and sexual abuse.

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In the following narrative, multiple forms of intimate partner violence and disloyalty are portrayed, which resulted in the participant experiencing pain and isolation. The participant continues to voice feelings of resentment towards her ex-boyfriend for allowing her to engage in sex work while they were in a relationship.

> *I was in a five-year relationship with a boy, who also physically abused me very much… He gave me two blue eyes and then I started selling drugs with him…and then I thought enough is enough, I had enough of you that uses and abuses me and walks all over me. You want to have a good time with whores while I sit at home. I was hurt… The time I was find* [sic] *out he was two-timing me I was very broken down. I was so-so break* [broken] *down because the thing that I do, I do for both of us. I don't need to do it, but he says he say*[s] *he loves me, he's my man so I have to go seek for work, you understand. If he really cared for me then why must I still do things like that* [sex work] *You understand, and he is the one who made me positive*. - Leanne

The experience of intimate partner violence, much like above, touched on the different types of abuse, however, the participant's ex-boyfriend also acted as her pimp.

> *I had one* [boyfriend] *but he did like, you know?* [He was] *using me…* [for] *substances, money, I must go out and prostitute for him… he was abusing me sexual*[ly], *physical*[ly] *and emotional*[ly]*… I've had an eye, I've had my teeth kicken* [sic] *out… my ex-boyfriend abused me. He actually made me feel like in, you know... I was thinking a lot about where I am in life*. -Deidre

4.4 Dehumanisation

Sex workers reported not experiencing the same rights and privileges as others outside the sex-worker community, in addition to having their humanity removed. The next narrative points toward the physical body of TGFs and alludes to clients viewing and treating them as a body, as opposed to a complete person with agency. The narrative provided shows how the participant enforces her self-respect by taking it when it is not given to her.

> *I take my money because I worked for it and it belongs to me. I sold my body to you now, you understand? It's still my body, you have to respect it, and I have to respect it myself.*

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If I don't respect it, then no one else is going to respect it. It doesn't mean because I'm selling it that I'm just a piece of trash. I'm human. - Leanne

They won't help you. They take, they take our rights away, they take our humanity away from us. They treat us like- like we are not like human… - Deidre

Being discredited and socially discriminated against by the general public was but another form of dehumanisation.

The way people in the road look at you and they don't even know who you are, and they look at you with the intention of, "you are no good for society". - Deidre

4.5 Regular clients

Relationships with regular clients were complicated, with some participants having met their intimate partners through sex work. Intimacy within the sex worker-client relationship arose, often blurring the lines of intimate partner and client. Furthermore, it was stated that clients acted as a source of financial and emotional support to the participants.

We met through sex, me doing sex work, he was one of my clients…He was regular, and we became closer and much closer, and I was like, he is also like on the streets, but he was a client, a good client you know, and hmm. Ja, I was we [sic] *getting closer and I told him we must stay together, so*[do] *our own thing, build our own thing, like a team thing, as long as we stay together*. - Brigette

It's different having a partner than being a client hmm lover, but sometimes you get so attached to clients that you start becoming [sic] *having a relationship. Like a girlfriend and boyfriend. You understand, but you get the few. The one, two, three or four that you get attached to that - that you know can support you in a time when you need them or a phone call where you can just pick up and call them. You can say so, they will always be there for you*. - Gretchen

Anytime I can phone. That's my regulars yes. They told me [to] *phone them anytime, ask them anything and they'll give me an e-Wallet it* [sic] *or transfer it to my Shoprite*

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account, the money for me. That's my personal client, but he thought now he spited [sic] *me or made me a fool, he never made me a fool because I got two people on the good road for me. Oh YES and that's where I met them. That's why sometimes I don't need to go out because it's unnecessary. I then do have money, why do I then have to go play with my life, it's just if there is* [sic] *complications I can't every time get them, or every time make a nuisance of myself asking them for cash, you follow? But if I don't need it then I'll go out, but if I really, if I really need it, as in a bigger amount of money then I'll ask them.* - Leanne

4.6 Substance use

Most of the participants reported having used alcohol and illicit substances, such as Mandrax and Tik – a South African slang term used for methamphetamine. Substance use and abuse were associated with partaking in sex work. The job is associated with multiple challenges, such as staying awake to work at night; a divide between sex work and moralising views; and fear associated with the work. Through using substances, the participants were able to (in some of the cases) dissociate from the reality they wished to escape, as described by a participant:

I'm an alcohol abuser. You have to have something in if you doing the things you doing [sex work], *because what person would do in a sober mind business? Who is just going to lay on your back without being intoxicated or without being* [sic] *alcohol in your system, because, just to think about* [it], *you*[r] *client is maybe your daddy's age, how do you feel maybe getting the client on your body? You understand that's why you have to have something inside of you, to do what you want to do. You going to think to yourself, "Wow, no, I can't, no this man could have been my father." It doesn't feel good, it's an uncomfortable feeling to sleep with an older man, you feel dirty afterwards. But if you're on drugs or you walk in drunk then you won't think about it. You follow what I'm saying, you won't have so much negativity on your brain. You follow what I'm trying to say.* - Leanne

A lack of self-assurance and worth is related to substance use, with the world described as a place that is not worth facing from a sober perspective. This quote is indicative of the participant's harsh reality.

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I needed something that was going to boost my self-esteem and give me that confidence to face that world, but am I really facing the world or is crystal meth facing the world? Because I don't want to face the world sober. - Andiswa

Fear related to sex work was one of the factors that contributed to substance use.

Yes, only crystal meth, Tik. Only because of the work that I do, hmm, and so I also started doing sex work and [pause] *I used to go with them, I was very scared.* - Wanda

Tik was described as not only instilling confidence but also used as a means of staying awake.

Ok, hmm, yes, I use substances, the reason that I use is the work that I do. Sex work, uhm, how can I explain? To do my work properly, to do my work right. I will never do it if I'm sober, but because I'm drugged I can do it, understand? How can I say? It gives me confidence, it gives me [the] *willpower to do the work and it keeps me awake, understand? To do things that I do.* - Brigette

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4.7 Theme three: HIV – A shared experience

Critical to note is that almost all participants indicated the pervasiveness of HIV infection that accompanies being a TFSW as indicated by the various quotes.

All of us under the bridge is HIV positive. - Wanda [30 years old]

Now can you imagine the stigma that we face as transgendered sex workers because most of us we have one common factor: HIV. - Andiswa [no age disclosure]

I'm transgender, I'm HIV positive and still single (laughingly) so, ja [yes]. - Sammy [29 years old]

I'm a transgender, I'm HIV positive hmm… - Leanne [30 years old]

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The sub-themes that emerged from participants' experiences of living with HIV were around reactions to receiving their HIV diagnosis (*"I found out I'm positive"*); challenges with adherence to ART; fear of disclosure of HIV status; self-stigma; barriers to health services ("*Oh AIDS, oh you come for TB*"); and '*Discrimination*'.

4.8 "I found out I'm positive"

Reactions to receiving an HIV-positive diagnosis varied from shock and disbelief to sorrow. Some of the women took precautions with clients, but 'gave in' to unprotected sex with 'regular' partners. Generally, they were aware of the HIV risk associated with sex work, because many of their 'sisters' were HIV positive. However, younger participants like Deidre, Wanda and Sammy reported greater distress and emotion when recounting how they received their HIV diagnosis. The reason could be because the news was fresher in their memories because of the shorter time duration since the event (HIV-positive diagnosis).

> *I was like doing a research, they were doing research on us at Groote Schuur and I don't know. I forget the place now, but they were doing research on us and taking bloods, and so on, and I found out I'm positive. Everything just went blank that morning, but hmm I didn't give up. I did ask the doctor, "what should I do now? Where should I go?" The doctor did tell me, then,* [and] *later on, they did tell me about it*. - Deidre

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> *I took the test and the sister ask*[ed] *me "why do I want to come test?". And I told her, no, because I'm a sex worker and I'm living with sisters who are sick and got the virus and I just want to know, because it's serious and I don't want to die. I had a lot of information about HIV, TB and STIs. So…* [Pause] *I won't kill myself, but I didn't tell anybody, and I was emotional that time. I was sitting in her office crying-crying-crying, and I couldn't accept, I wouldn't say I couldn't accept it, but I never knew I would get it because I always use condoms normally. Maybe one, two, three guys I will, you understand, so, so I don't know how long I did have* [sic] *the virus, only the time when I found out. I only started with treatment last year September*. - Wanda

> *"Why must we use a condom? Are you sick, because I'm not sic."* [describing condom negotiation between her and her ex-boyfriend]. *I told him* [I'm] *not sick because the last time I did have sex I did get* [sic] *tested I was negative. So, as I'm standing here I'm*

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telling you that, my status, I know my status. So, hmm, he was just like hmm keeping me in a - in a line where I actually have to, whereby I had to know that we will go test together, but we never [did]. *There was the one night where I was so over drugged, so we had sex and since then I said something with my body did not seem right* […] *So, I had my first test through Dr Johan and I did. I was positive, and I was so disappointed in myself, but I then knew I got it from him* [ex-boyfriend], *from no one else because I was very loyal hmm in my relationship. I never went with someone else or slept with someone else, and he was the only one I had sex with who I had sex without a condom*. - Sammy

4.9 Challenges with adherence to ART

Ten of the eleven women indicated that they were accessing or had accessed ART at some point in time, some of them indicated inconsistent ART adherence. They reported barriers to adherence such as lack of access to meet the basic needs of food and shelter. Further precipitating problems that bedevilled adherence were substance use, emotional abuse in intimate partner relations and a lack of or unstable support structures aimed at adherence. The variables that were deemed barriers were also linked to a sense of apathy relating to ART adherence, which echoed through the reports provided. The following narrative speaks to defaulting from ART for a lengthy period, because of a culmination of problems, such as an unfaithful and emotionally abusive partner and poverty:

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I have defaulted from last year June. I didn't was [was not] *on ARVs and I defaulted due to circumstances, complications. I was in a relationship where my boyfriend how can say, he was, he was, he was two-timing me for the other transgender. He broke me down, so I stopped with my ARVs. Due to complications, I'm also homeless. There's always an inconvenience, sometimes there isn't always food to eat, sometimes you can't take the tablets at night. You understand?* - Leanne

Personal experiences are used to illustrate the link between substance use and struggles with adherence. The participant recounts how her most recent drug relapse caused her to default from her medication, which led to her contracting TB and being hospitalised for half a year. She keeps her drug paraphernalia beside her medication as a reminder to avoid drug relapse.

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[If] *I want to smoke, I rather take the medication now, and I just look at it, you see because it's keeping me if you*['re] *going to take a lot of it, if you*['re] *not going to take it, you*['re] *going to die… because I'm now recovering from relapsing, from you see, from, you see, so I'm just trying, afterwards, you see I'm still limping, I didn't walk, I couldn't walk for, I was in a wheelchair and so on.*

Interviewer: *Okay, so you were in hospital because of-*

Defaulted on my meds… and get and get and getted [got] *TB and so-so, I was in… for six months I was in hospital… Since I came out of the hospital, I didn't take any of* [the] *drugs and goeters* [things], ... *I told you it can become, I take the meds out, it need*[s] *to stand there, I need to look at them, because the lollie* [paraphernalia used to smoke Tik] *is there and I will always keep the lollie as well, I'm not going to throw it away, cause its gonna to* [sic] *make me also stronger*. - Nancy

An apathetic stance relating to health-seeking behaviour and medication adherence was common among the group of women that can be seen in the poor health-seeking behaviour communicated in the following quote:

Nobody [referring to TFSW group] *is interested in taking their medication, nobody is interested in that at a certain time we must do our bloods and such things… You don't take medication, but nobody wants to be told*. - Jackie

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The instability or lack of support groups resonated through the accounts provided by the women. Support groups were described as a protective factor for medication adherence. However, these groups were erratic because of a lack of funding. While support groups did not solely address medication adherence, they did keep the women busy and in doing so, decreased the likelihood of excessive drug use and defaulting.

So, what worries me about this group, worries me about this group [TFSW], *it was funded, then funded by Health4Men, is now lots of these girls getting defaulting on their meds, you'll see now, so much struggling girls; drugs it's too much. That's why I'm doing the informal group thing, because getting them to you know* [pause] *to get them to stop doing drugs, but, to, maybe they can get less doing drugs… because you know. I mean we used to be together like in a group there was less of these* [sic] *stuff, and if you keep*

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them busy, there is less[sic] *things to do* [referring to drugs]. *Like if you keep you*[rself] *busy, you don't do bad things you know*. - Nancy

Here it is clear that a support group can play a central role in ART adherence, as they dispensed medication to the group when they met. The participant describes not being on ART since the group ended.

Well, we had a club called [name of group] *and hmm it closes down, so I haven't been on medication for quite some time now but seeing that I'm here now I can take some at Health4Men*. - Gretchen

Further to the abovementioned challenges, the issue of theft was highlighted as means of inflicting harm by robbing one another of life sustaining medication.

It's just sometimes you know even your friends they can steal your tablets to punish you. - Deidre

Another key point was the side-effects of antiretroviral drugs (ARVs), e.g. drowsiness, and how it impacted their work at night. This issue was addressed by taking medication at a more practical time.

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So, my ARVs usually the counselling sister says we must take our ARVs at 8 o'clock at night, so I told them I'm a sex worker, I can't take ARVs because the side-effects, because I'm a sex worker, I can't I'm working in the night. I come home at four or five in the morning, they said no then I take it at five, maybe six. Make it six o'clock, because I'm sleeping during the day until say hmm four o'clock I will wake up and chilling and get my things together for the night. So that is what I do, normally I take my pills in the morning, because the job I do don't [sic] *allow me to, because if I drink it make* [sic] *me, it make*[s] *me hmm, so relaxing, I just want to sleep. It makes me very sleepy.* - Wanda

4.10 Fear of HIV status disclosure

Failure to disclose posed a barrier to the relationships that the women held or could potentially have, which was based on the fear of the reaction to them disclosing their status.

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Furthermore, feelings of guilt echoed through the reports given by the women concerning their reasons for not disclosing, where one of them describes being her mother's only child. The fear of rejection from their romantic or sexual partners fuelled further non-disclosure, often injecting the notion of lying about their status.

> *Someday, if one day when it happens that I had enough, that I want to go home. I got from there hmm healthy with no illness and stuff. Now I have to go back there, and I have to repeat a whole part of my life because my family don't* [sic] *know… I haven't told them yet, we never had this discussion. So, I have to repeat myself again when I go home and there's the thing that's keeping me from going home.*
> Interviewer: *Okay, so the HIV factor is a barrier between you and your family?*
> *Yes, yes! I don't know what will, how will they act on it. Or how will they behave when I tell them.* - Sammy

The fear of disclosing her HIV-positive status to her mother impacted her adherence, as she could not take her pills in the presence of her mother when visiting. She continues to explain that the packaging of ARVs is indiscreet.

> *Hmm, how can I say? ARVs, the tablets are in a pot, a plastic pot, in a bottle and it makes a terrible noise, it's 'mos' big and to take it to my mother or to even drink it there. I'm scared she catches me with it and asks what it is.* - Leanne

Issues around disclosure in sexual relationships also arose, where the participant explains that she did not disclose her status to her partner for two months because of fear of rejection. She initially lied about her HIV status and engaged in unprotected sex with her partner. However, after two months in their relationship, both partners disclosed to one another that they were HIV positive.

> *So, I thought, why don't you want you to use a condom… So, I then didn't use a condom, I give it to him, but the next time I told him, let's do it condomised, because I was HIV positive. I was diagnosed, but I was scared to tell him, because I also lied to him, I told him I'm HIV free, but as two months pass*[ed]*, he told me he got to - I told him I got to tell you something and I'm sorry, but I can't keep it to myself because what I'm doing is*

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wrong, because I love you and I told him yes I'm diagnosed with HIV. I actually got emotional, because he also know[s] *and he knew he also had HIV.* - Wanda

4.11 Self-stigma

Internalising the stigma that surrounds being HIV positive affects how the participants view themselves. The internalised stigma is further expressed in the narratives that portray participants undervaluing themselves and depicting a spoiled identity. Views of such a nature influence perceived self-efficacy and important decisions about their health and future. Deidre details her powerless outlook on her current circumstances and life course, and how being HIV positive transcends into a pattern of self-destructive behaviour and predetermined choices.

Some of them you know, they like thinking: I'm HIV positive, I'm fucked up, I'm dying. They just give up, they just... then you tell yourself, "fuck it up, smoke, let's fuck it up." Then they just greet me, and I do the same thing over and over and over. So, in the end, you like them, you surrounded by them, you follow them, you have no choice. You stay with them, you are 24/7 with them so you will continue doing the things they will do, unless someone come[s] *and reach*[es] *out for you. Come* [to] *take your hand. Get you out of that place.* - Deidre

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The association of being 'clean' is continued here, where a participant recounts contracting HIV; she indicates viewing herself as 'unclean' or 'dirty' post-infection, thus splitting her identity into two periods based on before HIV and after.

It hurts for the fact that when I got to Cape Town, I was healthy and clean. And now because hmm, hmm life is unpredictable I don't know where I'm standing, as I am sitting as I am sitting here. - Sammy

She continues to apply pre- and post-HIV to her family relationship.

I grew up with a family which were [sic] *very supportive. Hmm, they support me in any way, but then I wasn't HIV positive yet.* - Sammy

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A hesitancy is depicted regarding pursuing a romantic relationship based on being HIV positive, with the participant explaining that she is not sure who will have her now that she is infected. Moreover, feelings of contention around dishonesty and infecting another person were voiced, where the participant proclaimed it murderous to lie about an HIV-positive status and infect one's partner in the process.

> *I'm just on that stage or on that level of, "who's going to take someone who is infected already, you tell me"? And infecting someone else, you*['re] *killing someone else without you telling your partner you are ill, what, what. It's* [a] *sickness. You can't do that to other people, to* [an]*other lady, to another mother's child, because that, that person don't* [sic] *deserve that. It doesn't mean that because you were disappointed in life that you need to disappoint other people. They don't deserve it. I'm speaking on behalf of myself, I've experienced it and I know how it feels…* [on being HIV positive]. - Leanne

4.12 Hopefulness in the face of AIDS

The presence of optimism and positivity was also visible among the participants regardless of the harsh circumstances. Jackie speaks of knowing what she would want out of life, in addition to prolonging her life through adhering to her medication.

> *You know 'mos' what you want out of life. Hmm, being HIV positive. I know now I can add years still to my life, but I must take my treatment.* - Jackie

In the face of the challenges relating to adherence, some participants displayed great pride in their adherence. Jackie explained that she implemented a regimen where she takes her medication at the same time each day. She further described keeping her medication on her when she leaves home, as it is always accessible. She continued to show her bag containing her pills and medication that she had on her.

> *Ja! You get so used to it, like, I'm taking it now six o'clock every day, when 7de Laan* [local soap opera] *is on, but you get so used to it, and I always make, like this is where the key comes in* [takes out her medication bag] *… Now I always have the packet with it in…but the key, this is 'mos' now the… Sometimes I'm two doors away from home, and I will always put two in here… then when I'm visiting, and the bag is not with* [me] *the*

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room is 'mos' locked so the key will always be with me. Someone two years back taught me how to drink a tablet without taking water. - Jackie

This thread is continued, where the participant discusses actively choosing to prevent further HIV infections among TGF youth by advising them to use protection. She further offered to accompany them to the clinic to get tested, indicating selflessness and using her experience of being HIV positive in a meaningful way.

I will tell them, if you want to knit [have sex] *use condoms because why I will say, "girl this sickness is loose because why I have it today, and I don't want you to have it, and if you don't know if you have it, if you don't know where to go, come with me to Health4Men, it's very nice". You feel comfortable, Health4Men is like home. So, I say, "know your status, I'll come with you".* - Wanda

After being dislodged from the support group she was part of, Gretchen began and concluded this extract by revealing that being exposed to the clinic again served as a source of hope and a reminder that her health is of great value.

No, besides just being glad that I came in, thank you for [pause] *I was so excited yesterday when Jackie tell me, I said "Oh I would love to see them, I hope Gayle is there" because we*['re] missing *the old woman. We missed her so* [pause] *and to see the doctors again, so it will because it give*[s] *us that little bit of hope for coming back to Health4Men, coming for your ARVs and so. But once something just close*[s] *down on you then you just, you just drop dead there and lose hope. But once you come back, I can see things for a few times you will build that courage into yourself in knowing, your health is important, your life is important, you need to go back. So, you will - you will do anything in your power in order to survive.* - Gretchen

The death of a 'sister' to some of the participants caused others to re-evaluate their attitudes towards medication adherence. Witnessing 'sisters' falling ill and dying of AIDS-related causes served as a catalyst in prompting her to start using ART.

I only started with treatment last year September [...] sisters got sick, sisters die, that actually made my eyes open and girls will have this conversation of "ja, want djy

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gebruikie djou ARVs nie" [yes, because you don't use you ARVs]. *So, I told them, but who are you to judge? You can't say that they*['re] *not using their medication, you*['re] *also not using your medication, because I can see you*['re] *not using your medication, because we most of the time together, but I take mine.* - Wanda

4.13 Barriers to health services: "Oh AIDS, oh you come for TB"

Participants described experiences of accessing health as traumatic, where they faced discrimination and stigmatisation by health workers and those who accessed the facility, as well as staff frequently breaching confidentiality.

It was, it was traumatising. It was traumatising because why it starts from the receptionist to the doctor and there's no confidentiality… Because sometimes [you] *enter a health care service where your own community members sit, and people start stigmatising you because why, even if you do not come for an HIV test, even if you come for a cold, and then, now, now that you are trans and they start making fun of you and before that everything had a colour line that people notice, "Oh AIDS, oh you come for TB" and so. Or even if you take a packet of condom*[s]*, packet of condoms they say, "Oh sex worker", but today people take condoms to clean their shoes. It's like they*['re] *talking to one another* [health staff] *then maybe the other one is going to the community that is sitting in the benches and why, because a lot of them, they know each other. Now the community wants to know "what's wrong with that" and then it gets spoken. Your files get to be spoken out… and then you got out of that room and you can see everyone is looking at you and you can feel that something is wrong, until somebody stands up and shouts something at you or they shout at you "You got AIDS. You bring illness and sickness".* - Gretchen

The experience of seeking health care after receiving an HIV-positive diagnosis at a clinic is unpacked where the participant is mocked and discriminated against, based on her gender identification. The aforesaid resulted in feelings of helplessness, where it is stated that she would choose death over the mistreatment she receives at public health facilities.

Since I've now discovered that I'm (pause) *I'm now HIV positive which means I need support from a clinic, I'm far from home. I'm not at home, where I have family support.*

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Now I'm sitting with this illness, but I'm actually shy and scared to go to a clinic, because when I got there. When I go there, people are watching at [sic] *me. People are making a mock of me and they are making a mock of something that I didn't choose to be. They* [are] *making a mock* [mockery] *of something that I don't have control of and it hurts me. Sometimes in the beginning then I thought, "Fok them, then I can rather die" because to go through this every time, it's, it's, it's not on. We*['re] *all human and I don't ask you nothing so why are you discriminating against me, why are you like such?* – Sammy

Visibility was conveyed as an issue that compromised confidentiality when accessing public health facilities for ART. The space that HIV-positive patients occupy in the clinic is a clear indicator of their status, alongside visible markers on the folders of those who are treated for HIV.

No, we can't cause they put a red sticker on your folder, and if you have a red sticker on your folder, you go to a separate room, you show the people what you have, and I don't wanna stigma more, because I'm staying in the same community as my mother… You understand, it's not really [confidential]. *They can already tell the world you are sick.* - Leanne

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A health worker drops ARVs under the bridge, which could be indicative of the barriers that the women face when seeking health care, as she felt it necessary to bring them their ARVs. Furthermore, it is expressed that the travelling distance from where participants reside to Health4Men is an issue.

The lady, with the tablets, from [name of previous support group], *Jill, come drop under the bridge. A baggage of tablets of the glitz girls, some of them are in prison, some of them are outside 'mos', so I 'soema'* [just] *took one pop of theirs and started drinking it. If I'm, I have now to come see this psychologist or something, talk about the defaulting, and then they gonna* [going to] *give now to come again, I don't know if I'm going to make it for that date because do you know how far it is for us to till* [sic] *here, yoh.* - Leanne

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4.14 Discrimination

Participants described being discriminated against based on their HIV status, where they were accused of being 'dirty' and killing other people. These difficult conditions were only intensified by additional vulnerabilities, such as homelessness and engaging in sex work.

> *It's getting rough and it's getting harder for us, us trans people out there. Especially the homeless ones, because you get accused of: You are the person who are*[is] *killing other people's children and so on.* - Deidre
>
> Interviewer: *Killing other people's children?*
>
> *With HIV you*['re] *infecting other people.* - Deidre

The incident sketched below caused the participant to stop keeping her medication on her body, after being publicly slandered and shamed by a police official – after finding ARVs in her handbag.

I was waiting for someone and then the cops come they just take my bag and took my bag, and they looking for condoms but I didn't have condoms, but what was hurting was they throw out, all my stuff and then they saw my ARVs, and then they told me, you, "Look here, you trash, you are sick, you are all dirty, you are all dirty Moffies and you still want to be prostitutes" just by seeing my ARVs… since that time I don't keep my meds on my body any more. – Nancy

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Throughout this section, the researcher attempted not to make interpretations that did not closely mirror the results. The strength of the dissertation lies in the narratives provided by the participants, therefore the researcher consciously tried not to interfere, or impose theory causing the meaning given by the participants to be lost. The researcher identifies as an intersectional feminist, and thus aimed to allow the participants to 'tell their own stories'. This section was purposely lengthy so that the voices of the story-tellers could be displayed in their own words. Furthermore, the interviewer's interaction is rarely displayed throughout the quotes in this section, as the findings is a platform for the participants to depict their realities and tell their truths.

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Chapter Five

Discussion

In this study, we set out to explore the experiences of TFSW within their families, occupation and the healthcare system, consequently resulting in the emergence of three themes: *Transgender female, Sex work* and *HIV*. The three themes that emerged have been approached as interlocking in nature, rather than additive. Also, these themes act as social identities and are viewed accordingly- as a singular-synergised identity of 'transgender female sex worker living with HIV'. The results are discussed through a 'Triple Decker Pizza' theory, as suggested by one of the participating women, who drew on a triple decker pizza as a metaphor to describe the experiences of multi-layered stigma. Each layer represented an identity, i.e. transgender female, sex worker and being HIV positive (see *Figure 5.1*).

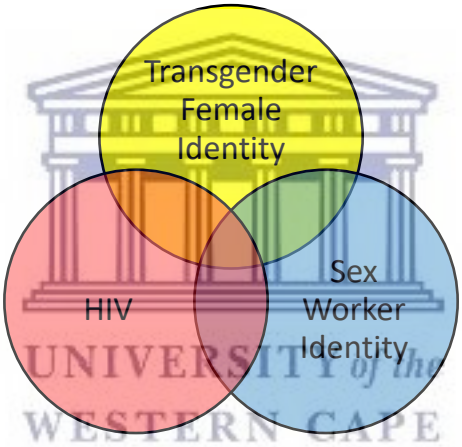

Figure 5.1 – Representation of multi-layered stigma

Given the context of social constrain in South Africa, identifying as a TGF while growing up has been shown to predispose individuals to increased levels of stigma. Along with this is an increased likelihood of negative social and health problems, e.g. homelessness, poverty and HIV infection, in comparison to heteronormative youth (Grossman & D'Augelli, 2008; Stieglitz, 2010; Wilson et al., 2009). This vulnerability during childhood and adolescence is often based on family rejection, isolation, abuse and abandonment, majorly resting on their gender identity. Of significance is that only one participant experienced complete acceptance from family members surrounding their gender identity as a TGF. Most participants identified at least a single-family member as having been abusive towards them or having rejected them based on their gender identity, with rejection ranging from a single-family member to their entire family. Most of the reporting women described being estranged from their biological

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families, thus losing a vital form of support. The findings of this study highlight detachment from family members as a result of their gender-based discrimination, which is supported by the work of Koken and colleagues (2009). They found that family hostility and neglect led to TGFs removing themselves from their family altogether (either by choice or being given no alternative). Furthermore, findings suggested that a lack of parental acceptance and rejection added a risk of poverty and homelessness, which is also illustrated in the results of the current research.

Contrary to the above, a few participants indicated having a supportive parent(s) or grandparent(s), who served as protectors - financially and/or emotionally. Losing a supportive family member also represented the loss of psychosocial support and financial stability, leaving the TGF destitute and isolated from their remaining family members, who were in most circumstances hostile or indifferent towards them. This family isolation and financial vulnerability only advance the marginalisation of this population in various spheres of life, often leading to further disempowerment.

Discriminatory attitudes displayed towards some of the individuals' gender identity was not always overt, nor was the family member(s) always aware of their discriminatory attitudes or behaviours. The participants reported this subtle oppression was harmful to their well-being, which is illustrated in the case of a participant who was forced to visit doctors and pathologized based on her gender identity. Until recently, the Diagnostic and Statistical Analysis for Mental Disorders – IV (DSM-IV TR) categorised a transgender identity as criteria for Gender Identity Disorder (DID) (Lev, 2005), it was only until the release of the DSM-V, where it was replaced with Gender Dysphoria (GD). Lev (2013) asserts that the presence of GD in the DSM-V is a contentious topic, as it still pathologizes individuals who do not ascribe to a socially normative position of gender (Lev, 2013).

All the participants had experienced homelessness at some point in their lives, with ten participants having reported that they were living on the street during the time that the interviews took place. Running away from home was asserted as a reaction to the oppressive circumstances that the participants faced while living with their biological family. Living on the street allowed the reporting women to display their gender identity – being a TGF – which had to be repressed at home. Grossman and D'Augelli (2008) along with Klein (1999) found that behaviour which is 'gender-atypical' is less admissible among boys than girls, further

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predisposing transgender female youth (TGFY) to high levels of intolerance from the family and community. Furthermore, the unfavourable view that society holds towards TGFY could be a reason for the high drop-out rates among many school-going TGFY, as well as running away from an abusive or intolerant home environment and eventually living on the street (see Grossman & D'Augelli, 2008; Koken et al., 2010; Singh, 2015; White Hughto, Reisner, & Pachankis, 2016).

Living on the street has led to participants seeking out an alternative network of support, as most TGFs were estranged from their biological family members once they reached the point of living on the street. Through connecting with other TGFs who live on the street, participants are able to create a new family of 'sisters' who share the identities of 'TGF'. These findings are corroborated by that of a study which was carried out in India on the TFSW population that focused on stigma, violence and HIV vulnerability (Ganju & Saggurti, 2017). The authors reported that participants described their peers, who also identified as TFSW as family.

A new finding in this study was that the participants reported creating formalised systems that have been emplaced by TGFs for those who live on the street. For example, the process of 'adoption', where a younger homeless TGF is adopted by an older one. One of the reporting women illustrated three generations of TGFs; she who was adopted, named and mentored by an older TGF, has now become a TGF mother herself. The process involves the adopting mother naming her newly homeless TGF 'child', and mentors her on how to survive on the street. Many of the reporting women described a hopefulness of improving the circumstances for the next generation of TGFs and leaving a positive legacy behind, with some having reported inviting newly homeless TGFY to come to live in their community. Interestingly, some of the participants reported educating newly homeless TGFY on HIV prevention and testing.

Regular clients have also served as a network of support by providing TFSW with both financial and emotional care and backing. The regular encounters between sex worker and client led to the blurring of boundaries between client and romantic partner, where in some instances, the relationship progressed from client to that of exclusive partner.

The reporting women painted a picture of an immensely transphobic society, with very few public spaces depicted as safe for TGFs. Transphobia ranged from microaggressions, such

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as judgemental looks, to hate crimes of severe physical violence that have proved to be nearly fatal for some of the reporting women. These crimes are perpetrated by strangers, where a participant was thrown from a moving train after a commuter realised that she was a TGF; police officials placing TGFs in a male cell and encouraging other cellmates to rape "the fresh meat"; and school peers who resort to bullying, where participants recall being referred to as 'faggots'. Being called a 'faggot' is a common slur that is used to insult TGFs (see Grossman & D'Augelli, 2008; Levitt & Ippolito, 2014). These acts of transphobia have also been described as a manifestation of structural stigma by Hughton et al. (2016), as the violence perpetrated against TFSW is purely based on them deviating from the societal normative position (gender and work), thus making the group more vulnerable to violence.

A tension of being both hypervisible and invisible at a single point in time appeared in the narratives of the participants. While some are targeted because of the hypervisibility of their gender identity, they are also structurally invisible when seeking legal protection, justice or access to basic public services (Lamble, 2009; Purdie-Vaughns & Eibach, 2008). The systemic neglect relating to this group of women make it difficult for them to exercise their human rights, with participants explaining that they do not report crimes perpetrated against them, i.e. rape, as they are deemed to be 'unrapeable' by some police officials. This notion of being viewed as 'unrapeable' is supported by the narratives of sex workers in Africa and South Africa (Scorgie, Vasey, et al., 2013), and more specifically Cape Town (Pauw & Brener, 2003) where the plausibility of them being 'rapeable' came into question.

These women experienced victim-blaming based on their stigmatised work and gender identity. Their stories relating to the aftermath of being raped illustrated transmisogyny[2] and the toxicity of hegemonic masculinities, with a medical doctor informing one of the participants that she could never be raped, as she was a man. In another instance, a police official asked one of the participants why she had not fought back, as she is a man. Occurrences like these could be inferred as the reason for TFSW feeling reluctant towards reporting crime perpetrated against them or accessing healthcare facilities. In the current study, findings related to rape, i.e. health care professionals and police officials' attitudes towards TFSW being raped (victim blaming), as well as TFSW' reluctance to report rape because of these attitudes. These findings

[2] The dislike or unfair treatment of transgender women (Cambridge Dictionary, 2018)

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mirror those of Ganju and colleagues (2017), who investigated the TFSW populations experiences of stigma, violence and HIV vulnerability in India.

Their less unfavourable experiences in the household, which resulted in them running away from home, forced the participants to live on the street and consequently, engage in sex work as a means of survival. Similar outcomes were found in studies conducted on homeless TGFY engaging in survival sex (see Nadal, Davidoff, & Fujii-Doe, 2014; Wilson et al., 2009). Sex work was introduced to all the participants by their network of 'sister's', which was described as a means to an end for personal survival. For some this was the only work they felt that they had ever done, furthermore, stating that based on their gender identity, this is the only work in which they could engage. Not only is this aligned to literature, which states that a large proportion of TGFs engages in survival sex, but also that the workforce discriminates against TGFs based on their 'non-conforming' gender identity (see Glynn et al., 2017). This resulted in sex work being one of the only viable options for generating income and survival.

One of the greatest dangers emphasised by participants was that of being exposed as a TFSW as opposed to a biological FSW. Being a TGF was described as a deterrent for clients who were seeking out services from a biological female, which in turn impacts business negatively for TFSW. For this reason, TFSW are not always honest about their gender identity and would rather take the risk of hiding their identity for financial benefits. The danger of being 'found out' can have fatal consequences, with many clients resorting to physical violence out of rage and some of the TFSW barely escaping with their lives.

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Certain scenarios also contain a grey area where the subject of gender does not arise at all and clients either assume that the sex worker is a biological female. Or, they act as though they were unaware until they have received the services and subsequently maintain that they were deceived – refusing to pay. Because of the criminalisation of sex work, sex workers have very little power in the circumstance where a client refuses to pay (Scorgie, Vasey, et al., 2013). Sometimes the TFSW can convince the client to continue or let her go without harming her once they realise that she is a TGF. Participants also reported that they had lost friends who were dishonest and 'found out'.

Other forms of violence include being coerced by an individual acting as a client and subsequently criminally attacked. This usually occurs into two scenarios: first, where the

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‘client’ orchestrate the TFSW to be beaten by a group of people in a remote location; or second, the TFSW is hired under false pretences and is brought to an apartment where they are expected to have sex with multiple men, often leading to rape. Participants further described being sexually coerced and exploited by police officials, which resonates with the findings of a study conducted on TFSW in the Dominican Republic, where police officials and landlords abused their positions of authority against participants by demanding sex (see Budhwani et al., 2017).

Sex workers and TGFs have an exceptionally higher prevalence of drug use in comparison to that of the general population (see Budhwani et al., 2017; Hoffman, 2014; Operario, Soma, & Underhill, 2008), which was confirmed by a high incidence of substance use among the participating women. Substances were used as a means of coping with the stigma attached to being transgender. Further reasons for using substances include overcoming the fear associated with sex work; to increase levels of confidence – ensuring optimal job performance; and allowing to depersonalise from a situation in which they would usually object to morally. In multiple studies, it was found that TGFs and TFSW reported using and abusing alcohol and methamphetamine (Brennan et al., 2012; Nemoto et al., 2013; Wilson et al., 2009). Substance use has been reported as having adverse effects on consistent condom use, increasing the TFSW’ risk of spreading and being infected with HIV (Brennan et al., 2012). Methamphetamine was also described as effectively countering the side-effects of ART – reported to cause drowsiness, which in turn negatively impacted some participants’ ability to stay awake and do sex work.

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Many of the issues surrounding sex work can be related to the criminalisation of the work, as the criminalisation allows police officials and clients to escape judicial punishment (Fick, 2006) when abusing TFSW. Participants described being the victim of various crimes, but not once did they portray an incident where they experienced justice. Through criminalising sex work the population is not only vulnerable relative to the law but are also treated as deviants of society (Decker et al., 2016; Fick, 2006; Krüsi et al., 2014). The stigma surrounding TFSW has been associated with a multiplicity of negative health outcomes, such as abuse, heightened intimate partner violence, substance use and an increased burden of HIV (Ganju & Saggurti, 2017; Lazarus et al., 2012). Intimate partner violence has been expressed within the research findings, where a romantic partner also acted as a pimp resulting in severe physical abuse and exploitation to support their partner’s drug use. Intimate partner violence has been found, in part, to be a consequence of the negative external attitudes displayed towards TGFs that

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permeate into the relationship and are subsequently internalised by a romantic partner (Henry et al., 2018).

While the literature shows that TFSW experience elevated levels of HIV infection and are at high risk of contracting HIV, an unexpected finding was that ten of the eleven participants indicated being HIV positive. The high incidence among the group of participants can be related to multiple factors, such as the interaction between their drug use, sex work and homelessness, along with their gender identity. Furthermore, South Africa has a particularly high HIV incidence rate, as opposed to the rest of the world, where 13.1% of the South African population is HIV positive (Statistics South Africa, 2018), thus placing this group at even greater risk of contracting HIV. Furthermore, there is no official policy in place around HIV prevention for TFSW, who have been identified by SANAC as a key population based on gender identity and occupation (South African National AIDS Council, 2017).

Some participants explained that they did not become infected through sex work, but rather by their romantic partner, as they only engaged in unprotected sex with their exclusive partner, consistent with the findings of other studies (see for example Budhwani et al., 2017; Nemoto et al., 2013; Nemoto, Bödeker, Iwamoto, & Sakata, 2014b). This could be based on a sense of safety that people feel in their romantic relationships (Hunter, 2010) as opposed to clients. Younger participants showed greater sadness when discussing their HIV status, as opposed to older participants. Older participants may have lived with the virus for a longer period, thus having more time to accept the diagnosis of a very stigmatised disease.

Antiretroviral therapy adherence is severely compromised when considering the results of this study, where many speak to defaulting from their ART therapy. Challenges that participants face regarding ART adherence and retention in care is has been linked to the oppressive circumstances that the women face, such as the gender-based discrimination and harassment carried out by health workers. Considering the dominant attitudes held towards gender identity, this is not uncommon on a structural level, where health workers refuse to refer to TGFs as women and only foster their already stigmatised gender identity (see Sevelius et al., 2016; Sevelius, Patouhas, Keatley, & Johnson, 2015). ART among the participants' adherence relied substantially on the adherence club (social support group) which had also focused on transgender-related issues and substance abuse that was, because of a lack of

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funding, cancelled. Some described defaulting from their ART medication after the termination of the club.

Further articulations of challenges connected to ART adherence was that of poverty, food insecurity and homelessness, which caused some to default from their ART for extended periods of time. Similar conclusions were presented in the literature, where homelessness and food insecurity have been widely associated with poor ART adherence (see Harris, Xue, & Selwyn, 2017; Kalichman et al., 2015). Homelessness can produce a vast array of problems, some of which are practical, such as no physical space to store medication, in addition to poor mental health and wellbeing, as well as substance use (see Brennan et al., 2012). Substance use was described by some participants as another difficulty linked to their ART adherence. The interaction of TGFs and HIV-risk can be viewed through a syndemic[3] lens, where several factors, e.g. sex work, substance abuse and homelessness interact synergistically, thus only adding towards the burden of a disease within a group. The former is evident when viewing the hyperbolic HIV prevalence that TFSW hold, an assertion that is supported in this study, as well as the literature (Baral et al., 2013; Ganju & Saggurti, 2017; Operario, Soma, & Underhill, 2008; Reisner et al., 2013).

TFSW are undoubtedly exceptionally vulnerable to HIV, with the state making little to no effort in improving the health services for this group, thus only increasing their risk of HIV infection. Furthermore, most of the literature surrounding TFSW focuses on HIV prevalence, but little in-depth research around their experiences of being HIV-positive. The primary focus on HIV prevalence alone does not allow TFSW a platform to articulate the intricacies of their experiences of being HIV-positive. Also, through focusing majorly on the prevalence of HIV among TFSW as opposed to their subjective experiences of being HIV-positive, the disease can become an extension of their identity. The danger is that it may perpetuate discrimination among the group and nurture the idea that TFSW are HIV-positive, as opposed to attempting to understand this phenomenon.

The results that emerged from this study points towards problems outside of the individual, where society has failed this group of women through constant interpersonal and community level abuse and dehumanisation based on their TGF gender identity. Furthermore,

[3] the mutually reinforcing interaction of disease and social conditions (Brennan et al., 2012)

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the stigma attached to their engagement in an 'immoral' criminalised job; in addition to being met with judgement and not receiving suitable health care – particularly for HIV (see Nadal et al., 2014) have led these women to be viewed and treated as deviants in society. One could argue that their situation is a product of a society that has demonised them and robbed them of self-worth.

Transgender female sex workers face severe living circumstances, with little support from any sources outside of their group of 'sisters' who face the same challenges. The women display incredible resilience and have developed the ability to survive in the harshest circumstances. Findings by Nuttbrock et al. (2014) similarly show that TGFs, who engage in sex work, develop a superior level of resilience to issues such as gender-based discrimination and violence. Regardless of these findings, it should be noted that from a human rights standpoint, no group of people should have to face these circumstances. Currently, there are no state structures emplaced or policies protecting the well-being of these women who are exceptionally vulnerable and structurally invisible (see Grossman & D'Augelli, 2008; Jobson et al., 2012; Thomas, 2013). Transgender female sex workers are forced to rely on NGOs with funding challenges for support. The inconsistent funding leaves challenges for groups offering services related to gender affirmation, and ART adherence that serves as a buffer for the TFSW are cancelled.

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In summary, these research results raise questions surrounding the existence of fundamental human rights (freedom from discrimination, basic human protection) among the vulnerable and marginalised living in South Africa. The narratives of inhumane treatment and living circumstances of TFSW bear testimony to a disrupt between the rights that are constitutionally granted to South Africans and the reinforcement of these rights. South Africa's post-apartheid legislative stance on gender is of the most progressive in the world, as it has been constructed on the values of democracy, human dignity and freedom (Nel & Judge, 2008). According to the South African Constitution, it is illegal to physically harm or discriminate against any person based on their sex or gender identity (South African Litigation Centre, 2016). Furthermore, South Africans who distinguish as transgender are permitted by the state to reassign their gender to one with which they identify in all their identifying documents. Despite these laws emplaced to protect all citizens of South Africa, the transgender community face severe discrimination and abuse perpetrated based on their gender identity (van der Merwe, 2018) and sex workers based on their work (Scorgie, Vasey, et al., 2013).

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Chapter Six

Conclusion and Recommendations

The aim of the current study was to enrich the knowledge and understanding among academics, public officials and the general population surrounding TFSW' experiences, with the intention to destigmatise and demarginalise sex work and nonconforming gender identities. In the current study, we advocate for justice and acknowledgement of the TFSW population while having offered them a platform to voice their needs. These findings are to be shared with NGOs and the general population, to campaign for equal access to all services, opportunities and human rights for TSFW.

Almost all of the literature currently in circulation concerning TFSW focusses on HIV. However, it is evident that the population's HIV vulnerability is a result of a collection of stigmatised identities, which have enduring effects on this group of women. Furthermore, this single focus of HIV alone can be potentially damaging, causing academics and researchers to view this population through a predefined perspective that removes their subjectivity and ignores them as individuals with agency. While many of the participants alluded to participating in survival sex as their last or only option, it is emphasised that they have taken action in supporting themselves under trying circumstances.

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The oppression that this group of individuals face occurs on multiple levels, and the necessity for better insights into addressing their marginalisation and needs are highlighted in this study. The consequences of oppression from the interactions of overlapping identities include those of gender-based discrimination and stigmatisation, GBV including their criminalised work status. These negative outcomes of the synergised stigmatised identities in a post-apartheid society only makes room for greater inequity. The marginalisation commonly facing participants started very early in life as a consequence of their gender identity. Therefore, it is proposed that greater efforts be made to educate the South African population about gender, sexuality and tolerance at a school level.

As has been suggested, research and knowledge should be produced surrounding TFSW living within the South African context, which will allow for their specific needs to be

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addressed and identify the current shortcomings of societies' understanding. The research as mentioned can aid in the development and implementation of interventions and policy aimed at TFSW. These could include sensitisation training for state officials when dealing with TGFs and SWs that would consequently address many of the barriers that TFSW currently face.

The limitations of the current research include the small sample size, which is partially due to the hard-to-reach population. Also, due to the qualitative nature of the study it cannot be generalised to all TFSW globally or to those living in South Africa. In addition, data collection, analysis and writeup was confined to the time period of a year, as this study was a mini-thesis submitted in partial fulfilment for the degree of Master of Arts in Psychology.

Recommendations suggest that more qualitative and work be conducted related to TFSW needs and using a legislative framework to improve their poor living circumstances. Also, that the legislation concerning sex work has consistently failed this population, and that sex work be decriminalised, or the current legislation revised. The current research hopes to inform academics of the struggles that TFSW in relation to stigma and discrimination on all ecological levels (intrapersonal, interpersonal, institutional, policy), and to pave the way for further research in the area of TGFs and SWs in South Africa, with a specific focus on stigma and discrimination. While individual interviews were believed to be the best method of data collection for this specific study, it can perpetuate the privatising of collective experiences that include isolation, abuse and violence, therefore, a focus group study may add value to the current body of literature (or lack thereof).

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Moreover, that interventions are developed at family-level for TGF, and that stakeholders intervene, with a focus on increasing psycho-social support, employment, access to equal healthcare and to create safe spaces for TGF and SW. It is also suggested that the struggles that TGFs, SWs and TFSW face not be confined to the space of academia, but that the media focus on the subjective experiences of these population groups

Emotional, physical and sexual violence is the price that TGFs pay to live sincerely. Moreover, no person's work should cost them their physical safety and humanity, which is the reality for many sex workers who live and work in South Africa. It is difficult to comprehend that this group of TFSWs are robbed of their human rights, rejected by friends and family and

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coerced through structural oppression to live out on the margins of society based on their gender and work identities.

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Appendix A: Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592283, Fax: 27 21-9593515

E-mail: shelleyannvickerman@gmail.com

INFORMATION SHEET: PERCEPTION OF TRANSGENDER SEX WORKER EXPERIENCE STUDY

Project title: The experiences of transgender female sex worker within their families, occupation and the healthcare system

What is this study about? The Department of Psychology at the University of the Western Cape is conducting a research study on the experiences of female transgender sex workers within their families, their work and their interactions with the health care system.

What will I be asked to do if I agree to participate in the study? If you agree to take part, you will be asked to participate in the study about your experiences as a transgender female sex worker within your families, the work you do and your interactions with the health care system.

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Would my participation in this study be kept confidential? Your name will be kept confidential, which means that no-one will know your name and your responses. Your name will not be included on any documentation, however confidentiality will be limited to the circumstance where you pose a risk of inflicting harm onto yourself or others. You can stop and withdraw from the study at any time. The information that you give will be secured and password protected, no one other than the two researchers, my supervisor and myself will be the only two people who will have access to this information. If we write a report about this research project, your name will not be used.

What are the benefits of this research? The current study hopes to enrich academics, public officials and the general populations understanding surrounding TFSWs experiences, adding to the destigmatisation and demarginalisation of sex work and nonconforming gender identities. Furthermore to advocate for justice and

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acknowledgement of the transgender sex worker population and to allow you a platform to voice their needs.

Do I have to take part in this research and may I stop participating at any time? You can stop taking part at any time. If you decide to stop taking part in this study nothing bad will happen to you.

What are the risks of this research? While the interview schedule has been constructed in a manner that does not address any issues directly aimed at trauma, themes may arise that could cause you to feel an array of emotions. I have experience in conducting semi-structured interviews in the area of sex work previously and will be attentive and mindful during the interviewing process, should you display any feelings of distress or uncomfortableness we may stop at any point. You will not be forced to answer questions that you are uncomfortable with.

Is any assistance available if taking part in the study makes me feel unhappy or sad? If the research or any part of this process results in you feeling unhappy or sad, arrangements have been made at NICRO Cape Town where a registered counsellor will be available to you. If you do not find NICRO to your liking we will make alternate arrangements elsewhere.

What if I have questions? This research is being conducted by *Shelley Vickerman and Umesh Bawa* at the University of the Western Cape. If you have any questions about the research study itself, contact

Study Coordinator: Shelley Vickerman and Umesh Bawa; University of the Western Cape; Private Bag X17, Belville 7535; Telephone: (021) 959-2283; Email: ubawa@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact: Head of Department: Dr. Maria Florence, Department of Psychology, University of the Western Cape; Private Bag X17, Belville 7535; Telephone: (021) 959-2283;. Email: cdavdis@uwc.ac.za

Dean: Professor Rhoda. Faculty of Community and Health Sciences. University of the Western Cape' Private Bag X17, Bellville 7535. Tel: 021 959 2150. Email: arhoda@uwc.ac.za

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This research has been approved by the Senate Research Committee and Ethics Committee of UWC.

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Appendix B: Consent Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2283, Fax: 27 21-959 3515

E-mail: shelleyannvickerman@gmail.com

CONSENT FORM

Title of Research Project: ***The experiences of transgender female sex workers within their families, occupations and the healthcare system***

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I am aware that everything I say will remain confidential, however confidentiality will be limited to the circumstance where I pose the threat of directly myself or others.

Participant's name …….

Participant's signature …….

Date …….

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Appendix C: Interview Schedule

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Appendix B: Interview Schedule

Part one:

This section of the interview will focus on building rapport, offering researcher information, completing the confidentiality agreements and other research ethics forms with the participant

- The participant will be briefed about the nature and aims of the study, as well as their rights as a participant.
- Researcher background and other information will be shared.
- Discussing the consent and ethics requirements of the study. Establishing informing written consent.
- Collection of information regarding the demographics of the participant: age, relationship status, dependents.

Part two:

These questions will form among others the core of the interview.

- Tell me a little about yourself
- Can you tell me about some of your experiences growing up in your family?
- Do you believe your relationships changed within your family once they became aware of your gender identity and occupation? If yes, could you describe how? If not, what do you believe caused you to not open up to them?
- How would you describe your current family/support system (this family is not restricted to biological family, but those you consider to be family)?
- Can you tell me about how you got into sex work?

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- How would you describe your experience of being a sex worker, taking into account the positive and the negative?
- What changes would need to be made in order to improve your working conditions?
- Do you feel that you can access healthcare services freely?
- Can you tell me about some of your experiences when accessing healthcare and how you have been treated by administrative staff, nurses, and doctors in the past?
- How did you feel during this interview?

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Appendix D: Ethical Clearance Letter

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

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South Africa
T: +27 21 959 2988/2948
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25 August 2017
Ms SA
Vickerman
Psychology
Faculty of Community and Health Sciences Ethics Reference Number:
HS/17/7/8

Project Title: The experiences of transgender female sex workers within their families, occupation and the health care system.

Approval Period: 25 August 2017 – 25 August 2018

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias

Research Ethics Committee

Officer University of the

Western Cape

PROVISIONAL REC NUMBER - 130416-049

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